

CAMP HAZE STAFF MEDICAL FORM

NAME: _____
FIRST, LAST, MIDDLE

HOME ADDRESS _____
PHONE NUMBER _____ **AGE** _____
DATE OF BIRTH _____ **HEIGHT** _____ **WEIGHT** _____

IMMUNIZATION RECORD: Please list all dates required

- (A) **MENINGOCOCCAL MENINGITIS** _____
- (B) 3 doses of **DIPHTHERIA TOXOID** _____
- (C) 3 doses of **ORAL POLIO VACCINE** _____
- (D) 1 dose of **LIVE MUMPS VACCINE** _____
- (E) 1 dose of **LIVE MEASLES VACCINE** _____
- (F) 1 dose of **LIVE RUBELLA VACCINE** _____
- (G) **LAST TETANUS BOOSTER** _____
- (H) **VARICELLA (Chicken Pox)** _____
- (I) **HAEMOPHILUS INFLUENZA TYPE B** _____
- (J) **HEPATITIS B** _____

Do you have any allergies: _____ (Please note) _____

Are you allergic to any medication _____

If so, indicate alternative medication used _____

Will you be bringing any medication up to camp? Yes _____ NO _____

If so, name of medication _____ Treatment for _____

Dosage _____ When given: _____ How often _____

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Please note any **Physical Restrictions**

Please note any **Dietary Restrictions**

Date of Camp Physical Examination _____

Physician's Name _____

Address _____ **Telephone:** _____

Staffer is physically able to enter into all camp activities.

Physician's Signature _____ Date: _____

PERSON TO NOTIFY IN CASE OF A MEDICAL PROBLEM:

Name: _____ Relationship _____

Address: _____

Phone Number(s) (Home) _____

(Cell) _____

Signature of Staff Member: _____

Date: _____