



UNIT _____ BUNK _____
POSITION _____

STAFF HEALTH AND MEDICAL RECORD

STAFF NAME _____	BIRTHDATE _____
HOME ADDRESS _____	AGE _____ SEX _____
CITY / ZIP CODE _____	PHONE _____
SOCIAL SECURITY # _____	

DOCTOR'S NAME _____ PHONE _____ CHART # _____

EMERGENCY CALL INFORMATION (parent/spouse called first unless otherwise requested)

MOTHER/GUARDIAN _____	WORK PHONE _____
	CELL PHONE _____
FATHER/GUARDIAN _____	WORK PHONE _____
	CELL PHONE _____
SPOUSE _____	WORK PHONE _____
	CELL PHONE _____

Additional emergency names and phone numbers (three additional names required - neighbor, friends or relative)

- NAME /RELATION _____ HOME PHONE _____
WORK PHONE _____ CELL PHONE _____
- NAME /RELATION _____ HOME PHONE _____
WORK PHONE _____ CELL PHONE _____
- NAME /RELATION _____ HOME PHONE _____
WORK PHONE _____ CELL PHONE _____

EMERGENCY MEDICAL INFORMATION (to be completed by parent/guardian)

ALLERGY: (medicine, food, insect toxin, other) _____
 Medication used for allergies _____
 Allergy medication sent to camp: YES _____ NO _____

HISTORY OF: Asthma _____ Convulsions _____ Diabetes _____ High fevers _____

Other medical conditions

Explain _____
 Any condition requiring medication _____
 Medication for above _____
 Medications brought to camp: YES _____ NO _____
 Do you wear: glasses _____ contact lenses _____ braces _____ hearing aide _____

*If any medication is coming into camp, it must be accompanied by a note. The note should state the recipient's name, the medication name, amount to be given and time to be given. Prescription and "over the counter" medications **must** be in original, labeled bottles or containers. For prescription drugs, pharmacies will provide a duplicate empty bottle which is labeled and can be sent to camp with the medication. These rules apply to overnight and late stay medications as well as daily medications.

AUTHORIZATION

In the event my child requires emergency medical care (as determined by the "Y" administration) while he/she is under "Y" jurisdiction, I authorize the doctor(s) and hospital to which my child is brought to perform all necessary emergency procedures and render treatment including the administration of anesthesia as necessary. I understand that attempts will be made to contact parents/guardians (and the emergency numbers listed on this form as necessary) before initiating this authorization.

Date _____ Parent or Guardian _____