HANDI*CAMP - STAFF HEALTH RECORD

*Handi*Camp is sponsored by Handi*Vangelism Ministries International*
P O Box 122, Akron, PA 17501-0122 717-859-4777

FULL NAME: _____ **DATE OF BIRTH:** _____ **GENDER:** _____
MONTH / DAY / YEAR

EMERGENCY CONTACT INFORMATION: *Provide information for those we can contact in the event of an emergency.*

First Contact: _____ Home/Cell: (_____)_____
Relationship: _____ Work: (_____)_____
Second Contact: _____ Home/Cell: (_____)_____
Relationship: _____ Work: (_____)_____

DOCTOR'S INFORMATION: *(in case of emergency)*

Doctor's Name:_____ Office Phone: (_____)_____

HEALTH INFORMATION: Approximate Height: _____' _____" Approximate Weight: _____lbs

Circle NO or YES for each item below. If YES, give approximate date of onset or mark "current" on the line provided. Please give an answer for ALL ITEMS!

AIDS, HIV+ NO YES _____
Asthma NO YES _____
Chickenpox NO YES _____
Diabetes NO YES _____
Heart problems NO YES _____
Hepatitis/carrier NO YES _____
High Blood Pressure NO YES _____
What is your "average" reading? _____/_____
Seizures NO YES _____
Type:_____
Are they controlled?_____
Tuberculosis NO YES _____
Other: _____

Give most recent dates for the following immunizations:
Tdap: _____ Measles: _____ Tetanus booster: _____ Meningococcal: _____ HepB: _____ Varicella _____
Covid (not required): _____ Covid Booster(s): _____ _____ Recovered from Covid (date, if applicable): _____

List **ALL MEDICATIONS**, *prescription* and *over-the-counter*, you use regularly OR on an as-needed basis.

MEDICATION	DOSAGE	PURPOSE

INSURANCE INFORMATION: *Workman's Compensation Insurance is in effect for any camp-related accident. It is strongly recommended that staff members have personal health insurance to cover any non-camp-related illnesses or medical situations which may occur during camp.* ***Are you currently covered by another health insurance plan?*** YES NO

If YES, name of Insurance PROVIDER: _____

Name of POLICY HOLDER: _____ID or POLICY NUMBER: _____

(over)

RELEASE STATEMENT: Carefully read the following statement and sign below.

NOTE: If staff member is under 18, a parent or guardian must read and sign the statement.

*The undersigned, intending to be bound hereby, realizing that it is Handi*Camp's desire to give each staff member a safe and beneficial stay, releases HANDI*CAMP and HANDI*VANGELISM MINISTRIES INTERNATIONAL, its officers, directors and employees, host families, and any and all individuals associated therewith from any and all liability for any injury or damage which may be sustained by the undersigned or property of the same, at or in transit to or from any camp conducted by or under their auspices. In case of medical or surgical emergency, I hereby give permission to the physician selected by Handi*Camp to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery. I also give permission for the release of medical information for the completion of insurance forms or on a need-to-know basis to health care providers.*

Signature: _____ Relation: _____ Date: _____