June 11-16, 2017
Staff
Deadline
May 1, 2017

Office Use

STAFF HEALTH FORM
INSURANCE INFORMATION

NAME: _____

Sex _____ Date of Birth _____ Deaf _____ Hearing _____

HOME ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____ WORK: (_____)_____

Health INSURANCE POLICY

Name of PolicyHolder:_____

Phone Number: _____ Policy/Group # _____

Type of Coverage:
_____

Please include a copy of your insurance card

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

ALLERGIES: ***Check all that apply***

Allergies	Bee sting	Poison Ivy	Penicillin	Poison Oak	Sumac	Dust	Epipen

Any special dietary requirements and/or restrictions:
_____

Last date of your Tetanus shot? _____
Please list any restrictions or limitations we should know about.
_____
_____

Blood Type

Check all that apply

Asthma	*Inhaler*	*Nebulizer*	*Diabetic*	*Sunburns easy*
Skin sensitivity due to other medical condition			Eczema	

Medication or Insulin

Medicine	Dose	Time administered/X per day	Office use

IN CASE OF AN EMERGENCY NOTIFY:

NAME:

_____

PHONE: (_____)_____ OTHER: (_____)_____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, _____ hereby give my permission to camp officials to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide medical, to order injection, anesthesia or surgical care should an emergency arise. It is understood that camp officials will make a conscientious effort to locate the emergency contacts listed above before any action will be taken. If it is not possible to locate emergency contacts listed. I accept the expense of emergency medical or surgical treatment. I hereby authorize DYC and Kamp Keirsey and its employees and agents to dispense medications and attend to other special needs I may need. I give Deaf Youth Camp's nurse permission to administer all medicines listed as per directions on container or written out.

_____ _____

Signature *Date*

Send this form with your application.