

CAMP WINNEBAGO



STAFF MEDICAL RECORD

Please return this with your Staff Information Sheet by JUNE 8th

NAME _____

ADDRESS _____

CITY _____ PROVINCE _____ POSTAL CODE _____

PHONE NUMBERS Home: _____ Cell: _____

DATE OF BIRTH _____

HEALTH CARD # _____ VERSION CODE _____

LAST IMMUNIZATION DATE (Polio/Tetnus) _____

ALLERGIES _____

DRUG ALLERGIES _____

Do you require an Epi-Pen for any of the above allergies? _____

RECENT ILLNESSES, OPERATIONS OR INJURIES (Please provide details)

IF THERE ARE ANY TREATMENTS, INJECTIONS OR SPECIAL MEDICATIONS TO BE GIVEN WHILE AT CAMP, STATE WHEN AND HOW TO BE ADMINISTERED

IN CASE OF MEDICAL EMERGENCY, CONTACT PERSON BELOW:

Name: _____ Relationship: _____

Phone Number(s) _____

PARENT'S SIGNATURE (For Staff under age 18) _____

STAFF MEMBER'S SIGNATURE _____ DATE _____