STAGEDOOR MANOR EMPLOYEE HEALTH HISTORY

(Please fill out and *bring with you to camp*. **DO NOT e-mail**)

Name: Last ______________________________ Age_______ Date of Birth *(mm//dd/yyyy)* ________________

First ______________________________

Sex: ☐M ☐F Preferred Pronoun: ________________ Phone #______________________________

Address___ ______________________________ Country______________________________

Emergency Contact _______ ______________________ Relationship______________________________

Cell Phone ____________ ______________________ Alternate Phone #______________________________

Insurance Info: Fill out the information below. Please attach a copy of the front & back of your health insurance card.

Policy Holder: ______________________ Insurance Carrier: ______________________________

Policy#______________________________

Carrier Address: ______________________________ Carrier Phone # ______________________________

Primary Care Provider/GP______________________ Phone #______________________________

Other Provider______________________________ Phone #______________________________

Health History:

Allergies:

Medications	No ◯ Yes◯	List: ______________________________
Food	No◯ Yes◯	List: ______________________________
Bee Sting	No ◯ Yes◯	List: ______________________________
Other	No◯ Yes◯	List: ______________________________
EPI-PEN	No◯ Yes◯	Date last used *(mm/dd/yyyy)*______________________________

Please check yes for any medical conditions you have or have had in the past.

Medical Condition	Yes	No	Comment	Medical Condition	Yes	No	Comment
Anemia	☐	☐		Fainting/Dizziness	☐	☐	
Anxiety	☐	☐		Head injury	☐	☐	
Arthritis	☐	☐		Headaches/Migraine	☐	☐	
Asthma	☐	☐		Heart Disease	☐	☐	
Auto Immune	☐	☐		Hepatitis – type	☐	☐	

Condition	yes	No	Comment	Condition	Yes	No	Comment
Back Problems	☐	☐		High Blood pressure	☐	☐	
Cardiac Disease	☐	☐		Kidney Disease	☐	☐	
Diabetes	☐	☐		Low Blood Pressure	☐	☐	
Neurologic Disease	☐	☐		Respiratory Disease	☐	☐	
Psychiatric Disorder	☐	☐		Seizures	☐	☐	

Any additional comments on Medical History:

Chronic or recurring illnesses not mentioned above:

Surgical History:

Any recent Hospitalizations or in-patient treatment:

Current Medications:

Medication	Route	Dosage	Frequency	Indication for Use

PLEASE ATTACH A COPY OF YOUR IMMUNIZATION RECORD.

This Health Form is correct & complete as far as I know. I hereby give permission for me to receive necessary medical care while at camp, including testing & medications. I give permission for camp to release any records required for necessary care and /or for insurance purposes. In case I cannot respond in an emergency, I hereby give permission to the physicians & hospitals selected by camp to administer treatment, including hospitalization.

Staff member signature____ Date: *(mm/dd/yyyy)*_______________