TOWERING PINES/WOODLAND
STAFF HEALTH FORM
Eagle River, WI 54521

NAME ____________________
SS# ____________________
Date of Birth ____________ Age ______
❑ Male ❑ Female

HEALTH HISTORY (must be updated within 6 months prior to camp season)

Home Address/Phone ____________________

Emergency Contact ____________________ Phone ____________

Please check the illnesses you have had:

❒ Measles
❒ German Measles
❒ Mumps
❒ Chicken Pox
❒ Asthma
❒ Diabetes
❒ Scarlet Fever
❒ Rheumatic Fever
❒ Epilepsy or Convulsions
❒ Bleeding Disorders

Allergies:
❒ Hay Fever
❒ Bee Sting
❒ Skin Rashes
❒ Medication ____________
❒ Food ____________

Other illnesses, injuries, operations or past medical treatment: ____________________

Activity or diet restrictions: ____________________

Current **medications**; Prescription & over the counter (send with instructions):

Name   Health issue   Instructions

1. ____________________
2. ____________________
3. ____________________

STATEMENT OF PHYSICIAN (Please attach a copy of the patients health history)

Is this patient up to date on necessary immunizations? _____ List date of booster: **Tetanus** ________

Is the patient under any medical or dietary regime that should be continued at camp? ________

Does he/she have any physical or mental condition that our nurse or camp doctor should know?

Your recommendations or any restrictions: ____________________

Date of health exam : _______ **(must be within the past 24 months)**

I have examined the above named and find him/her free of any contagious or infectious condition that could be conveyed to others. And, I find him/her physically fit to engage in strenuous physical activities without personal harm.

Physician's Name ____________________ Phone ____________
Address ____________________

Signature of Physician ____________________ Date ____________

EMPLOYEE

It is understood that the use of drugs not specifically itemized above or prescribed by a physician for medical treatment during the course of the camp season is considered to be grounds for dismissal.
This report must be returned to the Director no later than June 20 as a condition of employment.

Signature of Employee ____________________ Date ____________

If staff member is under 18 years of age: I authorize the Director or medical personnel selected by Towering Pines/Woodland to act on my behalf in event of emergency in all matters of health and welfare of my child.

Signature of Parent ____________________ Date ____________

Health & Accident Insurance coverage provided by ____________________
Address ____________________ Policy # ____________
Phone contact ____________________ Group # ____________
Please attach copy of insurance card

Revised 02/05