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 ____________________

Attach a copy of your health insurance card

Please check the illnesses you have had:

❒ Measles	❒ Diabetes	**Allergies**:	❒ Hay Fever
❒ German Measles	❒ Scarlet Fever		❒ Bee Sting
❒ Mumps	❒ Rheumatic Fever		❒ Skin Rashes
❒ Chicken Pox	❒ Epilepsy or Convulsions		❒ Medication____________________
❒ Asthma	❒ Bleeding Disorders		❒ 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, mental or psychological 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 19 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 _______________

Rev 4/16

**You may keep all medications/health aids private OR you can give them to the nurse who will keep them for you. If you choose to keep them private you must place them in a box or bag identified with your name and give this package to the nurse. No one other than you will be allowed to open your package. However, if you choose the privacy option you must disclose to the nurse all medications that could interfere with your physical, emotional, or mental ability to fulfill your job.