

INGHAM-OKOBOJI STAFF HEALTH FORM

PERSONAL INFORMATION

Full Legal Name: _____

Sex: M / F (circle one) Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Home Address: _____ City/State/Zip: _____

Parent /Guardian Name(s): _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Emergency Contact (other than a parent): _____ Phone: _____

Church Name: _____ City: _____ State: _____

MEDICAL INFORMATION

Are Immunizations Current? Yes No (circle one) Date of last tetanus shot: (month/year) _____

Have you received any COVID-19 vaccinations Y / N If so, what were the approximate dates (month/year): _____ & _____

ALLERGIES/ASTHMA/OTHER CONCERNS: (Please indicate if allergy is airborne, touch, or ingested exposure)

Food Allergy? _____ Severity: _____

Insect Allergy? _____ Severity: _____

Other/Medication Allergies? _____ Severity: _____

Staff Member carries an: Epipen Inhaler Reason: _____

Has you ever experienced asthma (exercise induced or otherwise): Y / N

Other Medical concerns/Activity Restrictions (Diabetes, Heart Condition, Seizures, etc.) Please Give Details:

Describe any other disorders or disabilities of which the camp needs to be aware (ex: ADHD, depression, anxiety, mobility limits, etc): _____

Please note any past medical treatments, surgeries or injuries which may affect you to carry out your job during camp life or in the event of emergency care: _____

Please list all medications, including OTC and vitamins, the staff member will be taking at camp. Be specific and add additional pages as needed for instructions and additional items

Medication	Dose	When is it taken?	Why is it taken?

If needed, can we administer acetaminophen/ibuprofen according to recommended guidelines? Y / N

If needed, can we administer sunscreen and bug repellent? Y / N

STAFF MEMBER'S MEDICAL INSURANCE INFORMATION:

Insurance Company: _____ Phone #: _____

Policy #: _____ Group #: _____ Policy Holders Name: _____

Primary Care Dr. & Phone #: _____

Release & Waiver of Liability Agreement/Medical & Media Release Form

**I give my permission for my child (myself) to participate in all aspects of the program except as noted.

**I understand that every effort will be made to contact the emergency contact in case the need of emergency medical/surgical treatment is required.

**But if it is important to do so, I hereby give my permission to the medical staff selected by the camp to secure proper treatment, to hospitalize, to order injection, anesthesia, x-ray or surgery for my child (myself) as named above.

**I understand that my insurance has primary coverage and Ingham / Okoboji insurance is secondary.

**I understand choosing to be at camp may increase their (my) risk of being exposed to any and all illness and understand there may be certain requirements expected of this child (myself) when illness arises.

**I give permission for any picture taken of my child (myself) to be used for promotional purposes.

BY SIGNING THIS DOCUMENT I (We) acknowledge these policies and affirm that all above information is accurate and true.

Signature of Parent or Guardian (if employee is minor) _____ Date: _____

Signature of Employee _____ Date: _____

Camp Staff Use:

Screened upon arrival to work:

Medications stored in secure location:

Code: _____

Date/Time: _____

Initials: _____