

# Pennsylvania Christian Camp Staff Health Form

To be completed and signed by adult staff.

Please print

Staff's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Age \_\_\_\_ M \_\_\_\_ F \_\_\_\_

Home Address \_\_\_\_\_  
\_\_\_\_\_

City State Zip

Home Phone ( ) \_\_\_\_\_  
Cell Phone ( ) \_\_\_\_\_  
Work Phones ( ) \_\_\_\_\_  
( ) \_\_\_\_\_

Family Physician \_\_\_\_\_  
Physicians Phone ( ) \_\_\_\_\_

Do you currently take prescription or non-prescription medication on a regular basis? If yes, \_\_\_\_\_  
please list them along with times to be administered: \_\_\_\_\_

Will you have medication that requires refrigeration? \_\_\_\_\_

Note: Please bring all medications in original prescription bottles!

"I give my permission to the camp nurse to administer the following medication to myself for the following complaints."

For headache, muscle ache, or sports injury:

Aspirin	_____ yes	_____ no
Acetaminophen	_____ yes	_____ no
Ibuprofen	_____ yes	_____ no

For upset stomach:

Antacid (Maalox)	_____ yes	_____ no
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For severe allergic reaction  
(swelling, itching, hives)

diphenhydramine (Benadryl)	_____ yes	_____ no
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Contact lenses \_\_\_\_\_ yes \_\_\_\_\_ no

Tetanus Immunization Date: \_\_\_\_\_

Other information that would be helpful to the camp nurse in the event that you have a medical emergency and are unable to communicate with the Nurse or EMS:

Our family insurance coverage is \_\_\_\_\_  
Policy # \_\_\_\_\_

I hereby authorize any representative of PCC to obtain any emergency medical treatment for myself that may be needed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**\*\*\* Please attach a photocopy of your health insurance card.**

Does your child have :	
Allergies: _____ yes	_____ no
<i>Please specify:</i>	
Asthma: _____ yes	_____ no
Diabetes: _____ yes	_____ no
Other:	