Mar 15-17, 2019

Staff Deadline - Mar 1, 2019

Office Use

_____
_____
_____
_____

STAFF HEALTH FORM AND INSURANCE INFORMATION

NAME: _____ Birthday _____

Sex: Male or Female **Deaf** ___ **Hearing** __ **Blood Type:** A+, A-, B+, B-, O+, O-, AB+, AB-

ADDRESS:_____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (_____)_____ WORK: (_____)_____

Health INSURANCE POLICY **Please include a copy of your insurance card**

Name of
PolicyHolder:_____

Phone Number: _____ Policy/Group # _____

Type of Coverage: _____

Doctor's Name: _____ Phone:(_____)_____
Address: _____
Last date of your Tetanus shot? _____

ALLERGIES: ***Check all that apply***

Allergies	Bee sting	Poison Ivy	Penicillin	Poison Oak	Sumac	Dust	Epipen

Any special dietary requirements and/or restrictions:

_____

Please list any restrictions or limitations:

_____

_____

Check all that apply

Asthma	*Inhaler*	*Nebulizer*	*Diabetic*	*Sunburns easy*
Skin sensitivity due to other medical condition			Eczema	

Medication or Insulin

Medicine	Dose	Time administered/X per day	Office use

IN CASE OF AN EMERGENCY NOTIFY:

NAME:

_____

PHONE: (_____)_____ OTHER: (_____)_____

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I, _____ hereby give my permission to camp officials to call a doctor or emergency medical service and for the doctor, hospital or medical service to provide medical, to order injection, anesthesia or surgical care should an emergency arise. It is understood that camp officials will make a conscientious effort to locate the emergency contacts listed above before any action will be taken. If it is not possible to locate emergency contacts listed. I accept the expense of emergency medical or surgical treatment. I hereby authorize DYC and Baptist Hill and its employees and agents to dispense medications and attend to other special needs I may need. I give Deaf Youth Camp's nurse permission to administer all medicines listed as per directions on container or written out.

_____ _____

Signature *Date*

Send this form with your application.