Counselor Health Record

Name: _____ Birthdate: _____ Age: _____

Church: _____ Medical Insurance: Y / N

Allergies with their reactions:

_____

_____

Health Conditions /physical limitations / Current Infectious Diseases:

_____

_____

_____

Medication:_____ Frequency: _____ Dosage: _____
Medication:_____ Frequency: _____ Dosage: _____
Medication:_____ Frequency: _____ Dosage: _____
Medication:_____ Frequency: _____ Dosage: _____
Medication:_____ Frequency: _____ Dosage: _____
Medication:_____ Frequency: _____ Dosage: _____

Date of last Tetanus Shot: _____

TB Skin Test Results: Date: _____ Type: _____ Results: _____

Emergency Contact:
Name: _____ Relation: _____ Phone #: _____
Name: _____ Relation: _____ Phone #: _____

I certify that this information is COMPLETE and correct to the best of my knowledge. I'm capable of performing the essential functions of my job and participating in assigned work duties. I understand my health information will be used by the camp nurse in providing care to me and may be reviewed by the Director or others as deemed necessary.

Signature : _____

Address: _____
Home Phone #: _____ Cell #: _____

Date: _____

Physician and Number:

_____

Medical Insurance Policy Carrier Name (Yourself/Spouse/Parent):

_____

***** PLEASE ATTACH A COPY OF THE FRONT AND BACK OF MEDICAL INSURANCE CARD *****