ANNUAL
Worker Health Form

NAME_____PHONE_____SEX____

ADDRESS_____

CITY_____STATE_____ZIP CODE_____

BIRTHDATE_____

CONTACT FOR EMERGENCIES_____
EMERGENCY PHONE NUMBERS (____)_____WK(____)_____

YOUR PHYSICIAN_____PHONE_____
Insurance Company:_____Policy/Group #_____

CURRENTLY ON MEDICATION _____YES _____NO
TYPE_____DOSAGE_____
TYPE_____DOSAGE_____

LIST ALL MEDICATIONS BRINGING TO CAMP: (Please notify camp nurse of medications you will have in your possession at camp. Some items may need to be kept in Infirmary.)

ALLERGIC REACTIONS: BEE STING_____PENICILLIN_____
OTHER_____

I HAVE THESE MAJOR HEALTH PROBLEMS:
HEART DISEASE_____ ASTHMA_____ DIABETES_____ OTHER _____

LIST ANY SPECIAL HANDICAPS:

PLEASE COMPLETE THE IMMUNIZATION RECORD BELOW **TO THE BEST OF YOUR KNOWLEDGE.**

VACCINES	**Year of last Booster**
Diphtheria Pertussis (Whooping Cough)**DPT*** Tetanus or	
Tetanus **TD*** Diphtheria	
or Tetanus	

"In the event of a medical emergency, I give my permission for a health care professional to do what is necessary for my health. I have reviewed this form and certify that all appropriate medical information is included and correct."

Date:_____

Signed:_____