



# CAMP LAWRENCE STAFF HEALTH FORM



**(Bring with you to Camp Lawrence when you come to Staff Training Week)**

Name: \_\_\_\_\_  
 Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Parents Name(s): \_\_\_\_\_  
 Full Address: \_\_\_\_\_  
 Parent's Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
 Health Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

## HEALTH HISTORY

IS STAFF MEMBER SUBJECT TO OR HAD:	YES	NO	EXPLANATION, DATES, ETC.
Ear infections (including swimmers ear)			
Bedwetting			
Unusual reactions to insect bites			
Hay fever			
Unusual sensitivity to poison ivy, etc.			
Epilepsy (convulsions)			
Asthma			
Diabetes			
Heart disease (rheumatic, congenital)			
Allergies (penicillin, aspirin, other medication; food)			
Operations or serious injuries (specify dates)			
Serious or chronic illnesses other than above			
Mental or Psychological Conditions			

Date of most recent Tetanus shot: \_\_\_\_\_

**AUTHORIZATION, RELEASE, AND WAIVER OF RESPONSIBILITY**  
*(Please sign below, if staff member is under the age of 18 have a parent sign)*

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed activities except noted. In the event of an emergency, I hereby give my permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the named person above. I hereby, for myself, my heirs, executors and administrators, waive and release any and all rights and claims for all loss or damages I may have against the CYO and Camp Lawrence and their representatives for any and all injuries suffered by me at camp. Additionally, I give permission for the free use of my name and/or pictures in any broadcast, telecast or other account of CYO events.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_