Health History - Cub Creek Inc.

Complete and return to:**16795 Hwy E, Rolla, MO 65401.** This form should be filled out and signed.

STAFF NAME_____BIRTH DATE_____SEX_____AGE_____

HOME ADDRESS_____PHONE_____

HEIGHT_____WEIGHT_____ HAIR COLOR_____EYE COLOR_____

PARENT OR EMERGENCY CONTACT

HOME ADDRESS_____PHONE_____

CELL PHONE _____ PAGER _____ OTHER_____

BUSINESS ADDRESS_____PHONE_____

SECOND PARENT OR EMERGENCY CONTACT_____

HOME ADDRESS_____PHONE_____

CELL PHONE _____ PAGER _____ OTHER_____

BUSINESS ADDRESS_____PHONE_____

ADDITIONAL EMERGENCY CONTACT_____PHONE_____

Health History (check, and give approximate dates where applicable)

Bleeding/Clotting Disorders_____
Convulsions_____
Diabetes_____
Frequent ear infections_____
Heart Defect/Disease_____
Hepatitis B Carrier_____
Hernia_____
Hypertension_____

Diseases

Chicken Pox_____
Measles_____
German Measles_____
Mumps_____

Allergies

Hay fever_____
Poison Ivy _____
Insect Strings_____
Penicillin_____
Other Drugs_____
Asthma_____
Foods_____

Other Diseases, allergies or details of above_____
Operations or serious injuries (dates)_____
Disability or chronic or recurring illness_____
Any specific activity to be limited by physicians advice_____
Dietary Modifications_____
Name of family physician_____Phone_____
Name of your medical insurance_____
Address_____Policy or group #_____Subscribers Name_____
Date of last physical examination_____

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct so far as I know. I acknowledge that there can be no guarantee of absolute safety against risk of unforeseen accident, and understand that although **Cub Creek Inc.** has taken precautions to provide proper organization, supervision, instruction and equipment for each activity, it is impossible to guarantee absolute safety. I acknowledge that I am able to participate fully in all camp activities with no restrictions.

Signature of staff _____

Witness_____Date_____

IMMUNIZATION HISTORY

Please record the date (month and year) of basic immunization and most recent booster.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) }DPT Tetanus	1 2 3	1 2
Tetanus Diphtheria }TD		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (SALK)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given_____(most recent)		
Haemophilus influenza		

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

Any treatment to be continued at camp:_____

_____

Any medication to be administered at camp (Please specify medications name, dosage, and time(s) to be given):_____

_____

_____

Any medically prescribed meal plan or dietary restrictions:_____

_____

Any allergies (food, drug, plant, insect, etc.):_____

_____

Additional health information or restrictions:_____

_____

Preferred Hospital_____

Signature of Physician attesting to the accuracy of the information on this form:

_____ Date _____

Name of person completing form:_____

Signature_____Date _____

ATTACH PHOTO HERE

PLEASE ATTACH A CURRENT PHOTO OF STAFF!