

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: _____

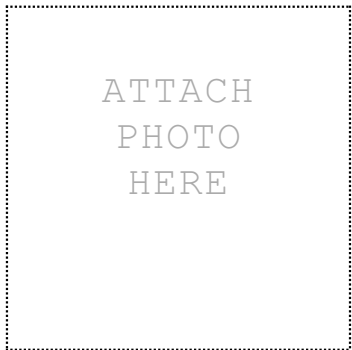
Preferred Hospital _____

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

_____ Date _____

Name of person completing form: _____

Signature _____ Date _____



PLEASE ATTACH A CURRENT PHOTO OF STAFF!