Camp Au Sable

2590 Camp Au Sable Drive Grayling, MI 49738 989.348.5491

Staff Medical Information

*Must be completed **each year before** you can begin working at Camp Au Sable!*

Name: _____ **Social Security Number:** _____
Last *First*

Date of Birth: _____ **Age:** _____ **Male:** _____ **Female:** _____ **Cell Phone:** _____
Mo/Day/Yr

Address: _____
Street or PO Box *City* *State* *Zip Code*

Parent/Guardian: _____ **Emergency Contact:** _____

Parent's/Guardian's Address: _____
Street or PO Box *City* *State* *Zip Code*

Emergency Phone Numbers: **Day:** ( ) _____ **Evening:** ( ) _____
Cell: ( ) _____

Insurance Information Attached: **Yes** ____ **No** ____ **If no, please explain:** _____
Important Note: Must have a photocopy of health insurance card (front and back) in order to treat staff in an emergency!

Physician/Health Care Facility: _____

Phone Number: ( ) _____ **Date of last physical exam (must be within past 24 months):** _____

Are all school physicals/immunizations up to date : **Yes** _____ **No** _____ **If not, please explain:** _____

Date of last tetanus (DPT/TD) _____ **If needed, may tetanus booster be given?** **Yes** _____ **No** _____
Mo/Yr

Allergies:	**No Allergies**	**Medication Allergies**	**Food Allergies**	**Other Allergies**
	_____	_____	_____	_____
		_____	_____	_____
		_____	_____	_____

Routine Medication:
_____
_____
_____
_____

Staff's Health History – Please Check

	Yes	No		Yes	No
1. Upset stomach?	_____	_____	8. Recent injury, infection, infectious disease?	_____	_____
2. Frequent ear infections?	_____	_____	9. Chronic or recurring illness/conditions?	_____	_____
3. Frequent headaches?	_____	_____	10. If female, menstrual difficulties?	_____	_____
4. Ever had seizures?	_____	_____	11. Any other health conditions requiring treatment?	_____	_____
5. Diabetes?	_____	_____	12. Any past medical treatment/operations?	_____	_____
6. Asthma?	_____	_____	13. Any emotional or social issues?	_____	_____
7. Any physical restrictions?	_____	_____	14. Any activities mentally/physically unable to do?	_____	_____
			15. Any medication that might impair ability to do job?	_____	_____

If "yes" please explain:
_____
_____
_____
_____

◇ ***There will be a head lice check at staff registration. Each staff must be lice-free before they can begin working.***
(To be filled in by medical staff at registration: no lice _____ recheck _____ yes _____)

I hereby give Camp Au Sable permission to provide routine health care (which includes over the counter drugs, first-aid for cuts, sprains, bruises, etc.), administer prescription medications, and seek emergency treatment as needed. In case of emergency, I hereby give permission to the camp physicians selected by the camp directors to secure proper treatment including: routine tests, x-rays, treatment, hospitalization, anesthesia, surgery, and to release any records necessary, as well as to provide or arrange necessary related transportation. I certify that the above information is correct and current to the best of my knowledge.

_____ _____ _____ _____
Signature of Staff / Parent (if under 18) **Date** **Camp Nurse** **Date**

Name _____
Last *First*

Date	Time	Medical Notes