YSSC STAFF HEALTH HISTORY

Name ____ Male Female
First Initial Last

Mailing Address: Street ____

City ______________________ State ______ Zip _______

Phone (____)________________ Date of Birth ____/____/____ Age______ Birth State ___________

Soc Sec ______________________ Drivers Lic ______________________ State ______

Health Report

Health problems/ Activity restrictions: ____

____

Drug allergies/ Allergic reactions (if allergic to bee stings, you must bring Epi Pen to camp): ______________________

____

Dietary restrictions: ____

____

Medications (must be sent in the prescription bottle with label): ______________________________

____

Past medical treatment (surgeries, diseases: ____

____

Current Tetanus shot required Year of Last Tetanus Shot __________ Hep B Vaccination Yes No

Approx date of Chicken Pox ________ Chicken Pox Vaccination Yes No MMR Vaccination Yes No

Spouse/Parent/Guardian Name (if applicable) ____

Home (____)________________ Work (____)________________ Cell (____)________________

Emergency Contact ______________________________ Relationship ________________

Home (____)________________ Work (____)________________ Cell (____)________________

Health Insurance Co ______________________ Policy # ____________ Ph (____)____________

Insurance Co. Address ____

Signature ______________________________ Date ________________

If you are under 18, please have your parent/ guardian read, sign and date the following:

In the event that I cannot be reached in an emergency and my child requires treatment, I hereby give permission to the physician selected by the camp administration to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named in this registration form.

Parent/ Guardian Signature ______________________________ Date ________________

All YSSC staff members must have had a medical examination by a licensed physician within the past 24 months.

1) Please attach a copy of your health examination record.

\- or -

2) Have a licensed physician complete the verification of health examination form below:

Verification of Health Examination

____ had a health
(name of staff member)

examination within the past 24 months, specifically on ________________.
(date of exam)

1) Please describe any current or ongoing treatment or medications : _______

____

____

2) Please describe any physical condition that might require restrictions on participation in camp activities or program : _________________________

____

____

__________________________________ ________________
(Signature of physician) (Date)

P O Box 1027, San Clemente, CA 92674
Phone: 800/775-9772 FAX: 949/369-9819