



Staff Medical Information

West or South

circle one

Position: _____

Name _____	Home # () - _____
Address _____	Work # () - _____
City _____	State _____ Zip _____

Name of hospitalization insurance company _____

Policy # _____ Policy holder's name _____

Family Doctor _____ Doctor's # () - _____

SSN _____ Person to be notified in case of emergency _____

Relationship _____ Home # () - _____ Work # () - _____

Current medication(s) _____

Reason for taking medication(s) _____

Circle any allergies: Hay Fever Poison Ivy Insect Sting Penicillin Other _____

List any dietary allergies _____

Do you have seizures? Yes No Date of last occurrence _____

List your past medical treatment if any _____

List any camp activity from which you should be exempted for health reasons _____

Please describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or considerations while at camp _____

Immunization Record	Please list the dates of these vaccinations:	Last Tetnus Shot: / /
DPT (Diphtheria Pertussis Tetnus): / /	Hepatitis B: / /	Varicella (Chicken Pox): / /
MMR (Measles, Mumps, Rebella): / /	Polio: / /	HIB (Heamophilus Influenza Bacteria): / /

In consideration for being allowed to participate in Youthfront Camp West/Youthfront Camp South, I agree to hold harmless and release Youthfront, its directors, officers, employees, volunteers and agents from liability for any fault, mistake, negligence, or omission causing damage, loss, injury, or death to me (hereinafter referred to jointly as Damage) arising from my attendance at the Camp, including any Damage arising from the provision of emergency medical treatment.

I have answered the above statements truthfully and completely.

Signature _____

Date _____