


STAFF MEDICAL INFORMATION FORM (All Staff)

Last Name (Family Name):		First Name (Given Name):		Middle Name:	
Permanent Street Address:				Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
				Birth date: (MM/DD/YYYY)	
City/Province:		State:	Postal Code:	Country:	
Home phone:		Position With JKCP:			
Primary Care Physician:			Phone:		
Dentist:			Phone:		
Name of primary insurance company:		Subscriber's name:		Group # (if any):	Policy #:
Your relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Primary Insurance Company Phone:					
Name of secondary insurance carrier: (if any)		Subscriber's name:		Group #:	Policy #:
Your relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other					
Secondary Insurance Company Phone:					
EMERGENCY CONTACTS					
Name:	Relationship:	Home phone:	Work phone:	Cell phone:	
Name:	Relationship:	Home phone:	Work phone:	Cell phone:	
Name:	Relationship:	Home phone:	Work phone:	Cell phone:	
Drug Allergies:			Other Allergies:		

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SURGERIES/HOSPITALIZATIONS

Month/Year	Reason	Month/Year	Reason

* Do you currently take any prescribed or over-the-counter medication (except vitamins)? If yes list below. Yes No

Drug Name	Dose	Frequency	Condition Treating

PLEASE NOTE: ONLY MEDICATIONS LISTED ON THIS FORM WITH CORRECT DOSAGE MAY BE CONSUMED AT JKCP. MEDICATIONS MUST BE BROUGHT IN THE ORIGINAL PACKAGE OR BOTTLE THAT IDENTIFIES THE NAME OF THE MEDICATION, THE DOSAGE, THE FREQUENCY OF ADMINISTRATION AND THE NAME OF THE PRESCRIBING PHYSICIAN (FOR PRESCRIPTION DRUGS). IT WILL REMAIN THE POLICY OF JKCP THAT PRESCRIPTION MEDICATIONS THAT ARE NOT LISTED ON THE MEDICAL FORM WILL NOT BE ALLOWED ON CAMPUS. IN ADDITION, THE AMOUNT OF MEDICATION A STAFF MEMBER BRINGS TO THE PROGRAM MUST NOT EXCEED THE PROPER DOSAGE NEEDED FOR THEIR STAY WITH US. WHILE AT THE PROGRAM, IT'S NOT A TIME TO ALTER THEIR MEDICATIONS ROUTINE. STAFF SHOULD CONTINUE TAKING THEIR MEDICATIONS AS THEY NORMALLY WOULD AT HOME. IF YOU HAVE ANY QUESTIONS OR CONCERNS REGARDING THIS POLICY, PLEASE CONTACT HUMAN RESOURCES.

*Do you have any disability or chronic recurring illness? If yes explain. Yes No

*Do you have any medically prescribed dietary restrictions? If yes explain. Yes No

*Have you been under the care of a psychologist or psychiatrist in the past two years? If yes explain. Yes No

*Do you have any other medical conditions not covered in this form which might make you medically unfit to work in a summer camp environment? If yes explain. Yes No

STAFF SIGNATURE
 The above information is true and complete to the best of my knowledge. In the event of an emergency, if I am incapacitated and my emergency contacts cannot be reached, I hereby give permission to the physician selected by JKCP to hospitalize, secure proper treatment for, and order injections, anesthesia or surgery as may be required in the doctor's professional opinion. I understand that working in a summer camp environment requires me to be physically active and unhindered by physical injury or illness in order to perform the duties of my job. I hereby affirm that I am able to meet this requirement.
 Signature _____

PHYSICIAN'S SIGNATURE (required if you answered yes to any question with an *)
 By signing this form, I confirm that _____ (patient) is unhindered by physical injury or illness and physically fit to work in a summer camp environment working with children and/or teenagers.
 *Physician Signature _____ Date _____
 Physician's Name (print) _____
 Address _____
 Phone Number _____