STAFF MEDICAL INFORMATION FORM (All Staff)

Last Name (Family Name):	First Name (Given Name):	Middle Name:	
Permanent Street Address:		Age:	Sex: ☐ M ☐ F

City/Province:	State:	Postal Code:	Country:

Home phone:	Position With JKCP:

Primary Care Physician:	**Phone:**
Dentist:	**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:

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 secure proper treatment 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 and illness in order to perform the duties of my job. I hereby affirm that I am able to meet this requirement.

Signature: ____ Date:__________________