

THE TAYLOR STATTON CAMPS

Winter: 59 Hoyle Ave. Toronto, Ontario M4S 2X5
Tel: (416) 486-6959 Fax: (416) 486-1837 E-mail: staff@taylorstattenamps.com
Summer: PO Box 10007, Huntsville, Ontario, P1H 2H2 (705) 633-5573

STAFF HEALTH HISTORY - 2010

NAME: _____ BIRTH DATE: _____

THIS FORM **MUST** BE COMPLETED, SIGNED AND RETURNED WITH YOUR SIGNED CONTRACT. IT IS A CONTRACTUAL OBLIGATION TO COMPLETE AND SUBMIT THIS FORM.

PLEASE NOTE:

- 1. PAY ADVANCES/CHEQUES will not be issued until this form is completed, signed and received by our office.**
- 2. Staff members who are over 18 years may complete and sign their own health history.**
- 3. Staff members under 18 years of age must have their health history signed by a parent.**
- 4. Name, Address and phone number of the family physician must be completed on this form.**

Ontario Health Card Number or Equivalent: _____

In Case of Emergency Notify: _____

Address: _____

Home Phone: _____ Office Phone: _____

Health History/Have you had:

- Y / N Chicken Pox
Y / N Diabetes
Y / N Epilepsy
Y / N Other Medical Concerns

Allergies:

- Drugs - Please specify: _____
 Food - Please specify: _____
 Nuts - Please specify: _____
 Bees
 Hay Fever
 Asthma
 Other - Please specify: _____

Allergies: If yes, please specify:

Please list any operations, serious illnesses or injuries you have had in the past 5 years and give details:

Please list any limitations that you may have to perform your duties:

IMMUNIZATION HISTORY: Are your immunizations up to date?

As we do not keep these dates on file for any staff member, please fill out in full to avoid delay of processing.

Immunization History: (Year of Last Booster):

DPT (Diphtheria, Pertussis, Tetanus)	_____
<i>or</i>	
TD (Tetanus & Diphtheria)	_____
Oral Polio (Sabin)	_____
Injectable Polio (Salk)	_____
Measles / Mumps/ Rubella	_____
Haemophilus influenza b (HIB)	_____
Hepatitis B	_____

Do you have any concerns that the Camp Doctor should know about?

Will you be bringing any treatments, injections or medications to Camp? If yes, please state when and how often you take them.

Weight (_____) _____

To the best of my knowledge, I _____ am in good health and able to participate in all camp activities. If I become exposed to any infectious disease between now and the time of departure for Camp, I understand that I must notify the Camp. In case of medical and/or surgical emergency, where parents/guardian cannot be contacted, I hereby give permission to the physician selected by the Camp Director or his/her appointed representative to hospitalize, secure proper treatment for and to order injections, anaesthesia or surgery for the above named and/or to contact the physician named overleaf, should it become necessary.

Staff Signature: _____ **Date:** _____

If you are under 18, please have your parent/guardian sign here: _____

Physician Name _____

Address _____

City _____

Phone _____

FOR CAMP USE ONLY

Date

Issues

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Treatment @ Camp (if needed).....

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Comments

Weight

Initials