THE TAYLOR STATTEN CAMPS

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

STAFF HEALTH HISTORY - 2017

NAME: ____ BIRTH DATE: _______________________

THIS FORM **MUST** BE COMPLETED, SIGNED AND RETURNED (TOGETHER WITH ANY DOCUMENTS REQUESTED) 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 must 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.
5. If you reside OUTSIDE of Ontario you must provide documentary evidence that you have full health coverage whilst in Ontario. Medical and hospital services are not free to non-residents of Ontario.

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 the allergen, the type of reaction you have, and severity of your last reaction:

____

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____

Dietary restrictions: If yes, please specify:

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____

____

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:

____

____

____

OVER ➡

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 (Diptheria, Pertussis, Tetanus) __________
or
TD (Tetanus & Diptheria) __________
Oral Polio (Sabin) __________
Injectable Polio (Salk) __________
Measles / Mumps/ Rubella __________
Haemoplhilus 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 ....

....

Treatment @ Camp (if needed)...

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Comments ....

Weight .... Initials ....