2020 **SOUTHAMPTON SUMMER DAY CAMP**
STAFF EMERGENCY MEDICAL FORM

NAME:_____ TODAY'S DATE _____/_____/_____
LAST FIRST

ADDRESS:_____
STREET CITY STATE ZIP CODE

BIRTHDATE:_____ PRESENT AGE:_____

IN CASE OF EMERGENCY NOTIFY: LIST TWO

1. NAME:_____
   RELATIONSHIP:_____
   PHONE:_____ CELL #_____

2. NAME:_____
   RELATIONSHIP:_____
   PHONE:_____ CELL#_____

*ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN FOR AN EXISTING CONDITION? 9Yes 9No
IF YES, DESCRIBE_____

*LIST ANY KNOWN ALLERGIES: (DRUGS, FOOD, INSECT BITES, PLANTS, ETC.)
_____
_____
_____

*LIST ANY MEDICATIONS TAKEN ON A REGULAR BASIS:
_____
_____
_____

*LIST ANY OPERATIONS, SERIOUS INJURIES, ILLNESSES & DATES:
_____
_____
_____

*DATE OF LAST TETANUS TOXOID VACCINE:_____

*ADDITIONAL INFORMATION A PHYSICIAN OR CAMP NURSE SHOULD BE AWARE OF:_____
_____
_____
_____

*NAME OF FAMILY PHYSICIAN:_____ PHONE:_____

*NAME OF DENTIST: _____ PHONE:_____

*THIS HEALTH HISTORY IS CORRECT TO THE BEST OF MY KNOWLEDGE AND I AM PHYSICALLY ABLE TO PARTICIPATE IN ALL DESIGNATED CAMP ACTIVITIES. **I CERTIFY THAT I HAVE HAD A MEDICAL EXAM BY A LICENSED PHYSICIAN WITHIN THE LAST 24 MONTHS.**

* STAFF MEMBER'S SIGNATURE_____

* PARENT SIGNATURE IF STAFF MEMBER IS UNDER 18 _____

THANK YOU FOR COMPLETING AND RETURNING THIS IMPORTANT FORM TO CAMP!