BRIARWOOD DAY CAMP

Staff Health Form

Year: 20___

Please complete this medical questionnaire with up to date information.

Name: ____

Address: ____

City: ____________________________________ State: _____________ Zip: ______________________

Home #: ___________________ Cell #: ____________________ Birthday: ________________________

Emergency Contact: ____

Phone # or #s: __________________________________ Relationship: ____________________________

Please list any chronic conditions: ____

Allergies: ____

Medications (please also identify reason, e.g. heart disease, diabetes, seizure, asthma, etc): __________

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Do we have your permission to administer Benadryl for insect bites or bee stings and Tylenol for headaches or other mild pain?

Yes __________ No __________

Date of last tetanus shot: ___________

Physician's Name: ____

Physician's Phone #: ____

Employee Signature: ____ Date: _______________