CHURCH OF GOD OF PROPHECY - NORTHEAST REGION
CAMP MINISTRIES

Staff Health Form

Please Print
Full Name
_____ DOB _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____

Gender: ☐ Male ☐ Female Email address _____

INSURANCE INFORMATION

Is the applicant covered by family medical/hospital insurance? ☐ Yes ☐ No

Name of Policy Holder _____ Relationship to applicant _____

Insurance Company _____ Policy # _____

Claim Address _____

EMERGENCY CONTACTS

Name _____ Phone _____

Relationship to Applicant _____

Name _____ Phone _____

Relationship to Applicant _____

HEALTH HISTORY

Please circle yes or no. If yes, give the date (mo./yr.)

Is there a history of:

Ear infections	Y	N	Date _____				
Rheumatic fever	Y	N	Date _____	Emotional problems	Y	N	Date _____
Convulsions	Y	N	Date _____	Eating disorders	Y	N	Date _____
Diabetes	Y	N	Date _____	Severe reaction to:			
Broken bones	Y	N	Date _____	Poison ivy, etc.	Y	N	Date _____
Hay fever	Y	N	Date _____	Insect stings	Y	N	Date _____
Asthma	Y	N	Date _____	Penicillin	Y	N	Date _____
Chronic Illness	Y	N	Date _____	Other medications	Y	N	Date _____
Hospitalization	Y	N	Date _____	Pain during Exercise	Y	N	Date _____
Surgeries	Y	N	Date _____	Seizures	Y	N	Date _____
Head Injuries	Y	N	Date _____	High Blood Pressure	Y	N	Date _____
Unconsciousness	Y	N	Date _____	Heart Murmur	Y	N	Date _____
Headaches	Y	N	Date _____	Back Problems	Y	N	Date _____
Sleepwalking	Y	N	Date _____	Skin Problems	Y	N	Date _____
Glasses, contacts or protective eyewear	Y	N	Date _____	Joint Problems: knees, wrists, ankles, etc.	Y	N	Date _____

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ALLERGIES: List all known medical and food allergies that cause severe or fatal reactions.

_____

_____.

MEDICATIONS: Please list ALL medications (including over the counter and non-prescription drugs) taken routinely. _____

_____.

SPECIAL DIET: If a doctor prescribed diet is required, please indicate diet and reason.

_____

_____.

COMMUNICABLE DISEASES:
Has the applicant had:

Chicken Pox	Yes	No	Date _____
Measles	Yes	No	Date _____
German Measles	Yes	No	Date _____
Mumps	Yes	No	Date _____
Other:			

* Results of most recent TB Test:
Date Given _____
Results _____

NOTE:

Authorization for medical treatment
This health history is correct and complete as far as I know.

I agree to the release of any medical records necessary for insurance purposes. I give permission to the camp to arrange necessary transportation for the above named applicant.

In the event that I cannot be reached in an emergency, this signature is my authorization for emergency treatment and I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the person named above.

SIGNATURE _____ DATE _____

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD.