

ECDC STAFF HEALTH HISTORY

	Date of Birth/	
Soc Sec	Drivers Lic	State
Health Report Health problems/ Activity	ty restrictions:	
	reactions (if allergic to bee stings, you must bring E	• • •
`	in the prescription bottle with label):	
	surgeries, diseases:	
Current Tetanus shot req Approx date of Chicken Po		Hep B Vaccination Yes No es No MMR Vaccination Yes No
Approx date of Chicken Po		es No MMR Vaccination Yes No
Approx date of Chicken Pouse/Parent/Guardian Name	ox Chicken Pox Vaccination Ye	es No MMR Vaccination Yes No
Approx date of Chicken Pouse/Parent/Guardian Name	e (if applicable) Work ()_	es No MMR Vaccination Yes No
Approx date of Chicken Pouse/Parent/Guardian Name	e (if applicable) Work ()_	es No MMR Vaccination Yes No Cell ()
Approx date of Chicken Pouse/Parent/Guardian Name	e (if applicable) Work ()	es No MMR Vaccination Yes No Cell ()

In the event that I cannot be reached in an emergency and my child requires treatment, I hereby give permission to the physician selected by the camp administration to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named in this registration form.

Parent/ Guardian Signature ______ Date _____

All ECDC staff members must have had a medical examination by a licensed physician within the past 24 months.

1) Please attach a copy of your health examination record.

- or -

2) Have a licensed physician complete the verification of health examination form below:

	had a healt
(name of staff member)	
examination within the past 24 months, specifically	on
	(date of exam)
Please describe any current or ongoing treatm	nent or medications :
Please describe any physical condition that	might require restrictions o
Please describe any physical condition that participation in camp activities or program :	

