Elks Camp Grassick
PO Box F, Dawson, ND 58428
701-327-4251
campgrassick@gmail.com

Staff Medical Form/Health History

Note: The information in this document will be kept in your confidential file for emergency purposes only.

IDENTIFYING INFORMATION

Name: _____ Gender: _____

Date of Birth: _____ Age: _____

Address/City/State/Zip: _____

_____

Phone Number(s): _____

Emergency Contact: (This should be someone you are comfortable with making medical decisions for you in case of emergency.)

Contact Name: _____ Relationship:_____

Address/City/State/Zip: _____

_____

Phone Number(s): _____

PHYSICIAN AND INSURANCE INFORMATION

Primary Physician: _____

Clinic where Physician Works: _____ Phone#: _____

Insurance Company: _____

Insurance Policy #: _____

EPILEPSY AND/OR SEIZURE HISTORY

Epilepsy or any history of seizure disorder ☐ Yes ☐No

If yes, list seizure type: _____

Date of last seizure: _____

Controlled by medication ☐ Yes ☐No

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ALLERGIES & DIETARY RESTRICTIONS

(Check all that Apply)

☐No Known Allergies ☐Latex Allergies ☐ Epi Pen Required

☐Allergies to Medications: _____

☐Allergies to Food: _____

☐Seasonal or Environmental: _____

☐Allergies to Insect Bites or Stings: _____

List any special dietary needs including allergies and foods you avoid for medical or religious reasons:

VACCINES

Are all vaccines up to date? ☐ Yes ☐No Covid-19 Vaccine? ☐ Yes ☐ No

Date of last Tetanus vaccine: _____

WELL BEING

Have you been diagnosed with or experienced any of the following:

Depression ☐ Anxiety ☐ OCD ☐ Bipolar Disorder ☐ Panic Attacks ☐

BPD/Personality Disorders ☐ ADHD ☐ Eating Disorder ☐ PTSD ☐

Sleep Problems ☐ Self-Harm ☐ Suicidal Feelings ☐ Other: _____☐

How can we best support you through these concerns while you are at Camp Grassick?

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Please describe information relating to mental health status, including, but not limited to: self-harm, hospitalization, participation in therapeutic programs, increased depression or anxiety, suicidal ideation, or other concerns:

MEDICATIONS

Please list medications you will be taking while at Camp Grassick or attach a list:

Medication: Time(s): Dosage:

Note:If you use medical marijuana, a copy of your medical card must be provided to the director.

Are there any OTC medications that you should **NOT** take? _____

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HEALTH HISTORY

Please list any recent surgeries, infections, or serious illnesses:

Have you ever been diagnosed with or experienced any of the following conditions?

(Check all that apply)

☐Arthritis ☐Asthma ☐Bleeding/Clotting Disorders

☐Concussions ☐Diabetes ☐Frequent Ear Infections

☐Hepatitis ☐Frequent Headaches/Migraines ☐Frequent Sinus Infections

☐Hearing Impairment ☐ Heart Defect/Disease ☐High Blood Pressure

☐Heat Illnesses ☐Mobility Concerns ☐Mononucleosis

☐Loss of consciousness/Fainting ☐Pneumonia ☐Sleepwalking

☐Stroke/TIA ☐Vision Impairment

Please elaborate on any of the checked boxes if necessary:

Are there any other specific concerns or pertinent information concerning your health that the administration of Elks Camp Grassick should be aware of or that may affect your ability to do the job you were hired for?