Staff Health Record Form

Employee Information:

Name:

Position:

Date of Birth:

Gender: Male | Female | I Prefer Not To Say

Address:

Phone Number:

Email:

Emergency Contact Name:

Emergency Contact Phone Number:

Relationship to Emergency Contact:

Shirt Size: Please circle your preferred shirt size: S | M | L | XL | XXL | XXXL | XXXXL

Health Information:

Do you have any chronic medical conditions? If yes, please specify:

Are you currently taking any medications? If yes, please list:

Do you have any allergies (food, medication, insect stings, etc.)? If yes, please specify:

Have you ever had any serious illnesses or surgeries? If yes, please provide details:

Immunization History:

Tetanus (Td/Tdap): Date of last vaccination:

Measles, Mumps, Rubella (MMR): Date of last vaccination:

Hepatitis B: Date of last vaccination:

Varicella (Chickenpox): Date of last vaccination:

Other vaccinations (e.g., influenza, COVID-19): Date of last vaccination:

Medical Insurance Information:

Insurance Provider:

Policy Number:

Group Number:

Emergency Medical Consent:
In the event of a medical emergency where immediate treatment is required, I authorize the staff of Kimball Camp Outdoor Center to obtain necessary medical treatment for myself. I also authorize the release of any medical information necessary for the treatment.

I also certify that all of the information included above is true and accurate to the best of my knowledge.

Signature: ____ Date: _______________