



HMBA Camp Ministry Team

Staff Medical Form

*Please Print Legibly. Please **Initial** or **Circle** Where Applicable.

_____ Male / Female _____ / _____ / _____
 (Name) (Gender) (Age) (Date of Birth)

EMERGENCY CONTACT INFORMATION

1 ST Contact Name	Phone	Relationship
2 nd Contact Name	Phone	Relationship

MEDICATIONS

If you have any prescription(s) *or* over-the-counter medication which needs to be dispensed during camp? **YES NO**
 (If you answered "YES," please list below)

MEDICATION	DOSAGE	AMOUNT TO BE GIVEN	TIME OF DAY
1.			
2.			
3.			
4.			

Please continue on a separate piece of paper, if needed.

MEDICAL HISTORY AND CONDITIONS

Date of last tetanus shot _____

Do you have any food allergies (if so, please list them out)

Do you have any medical allergies (if so, please list them out)

_____ **All medications must be turned into the camp nurse (or other medical personnel) at the time of registration. This includes all over-the-counter medications. NO medications are to be in the cabins.**

Initial

_____ **NO perscription medications will be given to any staff/volunteer by the camp nurse (or other medical personnel) if it is not in it's original prescribed container. NO pre-filled/poured medications will be allowed.**

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