



73 East Valley Brook Road
Long Valley, New Jersey 07853
Phone: (908) 876-3429
Fax: (908) 876-4635

STAFF MEDICAL HISTORY FORM

To Be Completed By Employee or Employee's Guardian.
Please Mail this form back to Meadowbrook by April 30, 2010.

Name _____ Date of Birth _____

Address _____ Height _____ Weight _____

City, State, Zip _____ Gender M F

Home Phone _____

Emergency Contact #1: _____ Relationship: _____

Emergency Contact #1 Phone: _____ Emergency Contact #1 Cell: _____

Emergency Contact #2: _____ Relationship: _____

Emergency Contact #2 Phone: _____ Emergency Contact #2 Cell: _____

Emergency Medical Information (Circle)

Asthma	Convulsions	Fainting Spells	High Blood Pressure
Contact Lenses	Diabetes	Heart Trouble	Migraine Headaches

Allergy or reaction to any medicine, food, plants, and/or animal/insect toxin. Yes No (If yes, please explain)

Any other condition that may require emergency or special care, medicine or knowledge? Yes No (If yes, please explain)

Insurance Information

Insurance Carrier/Plan Name: _____

Insurance Carrier Address: _____

Insurance Policy Number: _____

Group Number: _____

Prescription Plan #: _____

Medical Contact Information

Physician: _____

Phone: _____

Dentist: _____

Phone: _____

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Medical History

Any Past or Present History of: (please circle)

Back, Limbs, Joints	Yes	No	Heart	Yes	No	Serious Illness	Yes	No
Behavioral Condition	Yes	No	Heart Murmur	Yes	No	Serious Injury	Yes	No
Braces / Retainer	Yes	No	Hernia	Yes	No	Sinus	Yes	No
Chest, Lungs	Yes	No	Immune Deficiency	Yes	No	Skin, Glands	Yes	No
Contact Lenses	Yes	No	Kidneys	Yes	No	Stomach, Bowels	Yes	No
Deformity	Yes	No	Menstrual Problems	Yes	No	Surgery	Yes	No
Ears	Yes	No	Nose / Nosebleeds	Yes	No	Teeth	Yes	No
Eyes	Yes	No	Physical Limitations	Yes	No	Tonsils	Yes	No
Head Injury/Concussion	Yes	No	Pneumonia (recurrent)	Yes	No	Urine Infection	Yes	No
Hearing Aid	Yes	No	Rheumatic Fever	Yes	No	Other (explain below)	Yes	No

Please explain any Yes answers _____

Are you currently under medical care? Y N (If Yes, Explain) _____

Do you take any medication? Y N (If Yes, Explain) _____

AUTHORIZATION

To the best of my knowledge, the medical history is correct and complete. I know of no reason to restrict activity and give my permission for participation in all activities. I give permission for a Meadowbrook Country Day Camp staff member to administer an emergency Epi-Pen if deemed necessary. In the event I cannot be reached in an emergency, I hereby give permission to Meadowbrook Country Day Camp to take me/my child to the hospital or any outside physician selected by the camp when deemed necessary. Furthermore, I hereby give permission to such hospital or physician to hospitalize, secure proper treatment for, and/or order x-rays, routine tests, medications, injections, anesthesia and/or surgery for me/my child named above, without limitations. I understand that all medical bills for services rendered by anyone other than the camp's medical staff are my responsibility. I authorize the release of any medical information or records related to treatment, referral, billing or insurance purposes related to me/my child.

I further authorize the camp medical staff to discuss any medical conditions with the Director, his/her designee, or my/my child's supervisor when the medical staff, in its sole discretion, believes such communication to be in my/my child's best interest.

Staff Member Signature _____ Date _____
 (to be signed by parent or guardian, if staff member is under 18 yrs of age)

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 Long Valley, New Jersey 07853
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