PLEASE NOTE: This person will be hired as a Counselor and will be participating in strenuous activity, which could include one or more of the following: athletic competition, hiking, boating and outdoor activities. Staff will spend much of their day in the sun, please not if staff has any sun restrictions.

TO BE COMPLETED BY A LICENSED PHYSICIAN.

Please check all information on both sides of the health form. Be sure to include your signature, date, phone and address.

Review immunization for youth under 18—tetanus and diphtheria, measles, mumps & rubella vaccines; trivalent oral polio vaccine are required**. Adults are required to have tetanus booster.**

MEDICAL HISTORY:

	YES	NO
1. Serious Illness	___	___
2. Serious Injury	___	___
3. Eye Disease	___	___
4. Surgery	___	___
5. Ears	___	___
6. Nose/Sinus	___	___
7. Skin/Glands	___	___
8. Teeth/Tonsils	___	___
9. Dentures/Bridges	___	___
10.Chest/Lungs	___	___
11. Heart	___	___
12. Heart Murmur	___	___
13. Rheumatic Fever	___	___
14. Stomach/Bowels	___	___
15. Appendicitis	___	___
16. Kidney/Urine	___	___
17. Sun Sensitivity	___	___
18. Diabetes	___	___
*___Insulin or ___Non-Insulin *		
19. Infection	___	___
20. Hernia/Rupture ___	___	
21. Back/Joint/Limb ___	___	
22. Depression ___ ___		
23. Deformity ___	___	
24. Seizure ___	___	

25. OTHER: _____

_____

_____

Give dates & details for any YES answers.

_____

_____

_____

_____

_____

_____

_____

LIST ANY PHYSICAL RESTRICTIONS OR LIMITATIONS

_____

_____

_____

_____

_____

IS STAFF PERSON FREE FROM COMMUNICABLE DISEASES? YES NO

Has he/she been immunized against Hepatitis "B"?
Yes ____ No____ Results: +_____ or -- _____

TUBERCULOSIS TESTING

Date of last test: _____; PPD_____ **Mantoux**_____
Results: +_____ or --_____

EMERGENCY MEDICAL INFORMATION:
(Staff person has or is subject to)

___Diabetes ___Seizures
___Allergies ___Asthma
___Arthritis ___Heart Condition
___Bleeding D/O ___Fainting Spells
____Special Diet (attach dietary sheet) ___Eating D/O
Other: _____

LIST ANY KNOWN ALLERGIES: _____
_____
_____

VEGETARIAN/SPECIAL DIET REQUIRED? __Yes __No
Describe: _____
_____

VISION: O.D. _____ O.S. _____ ETIOLOGY/Dx of Visual Impairment: _____
Hearing: Normal_____; Degree of Loss _____
ETIOLOGY/Dx of Hearing Impair: _____

HEIGHT: _____ WEIGHT: _____ IN LBS.

BLOOD PRESSURE: _____ PULSE:_____

IMMUNIZATION RECORD/DATE:

MEASLES: _____
MUMPS: _____
RUBELLA: _____
PERTUSSIS: _____
VARICELLA: _____
TENTANUS: _____
POLIO: _____
DIPTHERIA: _____
HEPATITIS: _____
MENINGOCOCCAL: _____

_____
(Physicians signature)

_____
(Print physicians name)

Address:

_____

_____

Phone number: _____