# Nichols Day Camp

**P.O. Box 472 ~ Blue Hill, ME 04614**
**Phone (207) 374-9906 ~ Fax (207) 374-5862**

## 2017 Staff Medical Form

**THIS MEDICAL FORM AND YOUR SIGNED CONTRACT MUST BE COMPLETED AND MAILED TO THE CAMP OFFICE BEFORE ORIENTATION BEGINS.**

**Today's Date:** _____ **Birth Date:** _____

Name: _____Age at camp: _____
Last First Middle initial

Mailing Address:_____
Street City State Zip

Parent/Guardian (if counselor is under age 18)_____

Home Phone: _____ Cell Phone _____Work Phone: _____

Email:_____

**Emergency Contact**:
Name: _____Relationship: _____

Home Phone: _____Cell Phone _____Work phone: _____

**Insurance information**:
Is the participant covered by family medical/hospital insurance? Yes _____ No _____
(The employee is not required to have medical insurance to work for us.)

**Permission to Provide Necessary Treatment or Emergency Care:**
I hereby give permission to the medical services provider selected by the camp representative to order x-rays, routine tests and treatment; and to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for my child or myself. In the event that I cannot be reached in an emergency, I hereby give permission to the medical services provider selected by the camp representative to secure and administer treatment, including hospitalization, for the person named above.

_____**Date** _____
Signature of employee (18+), or parent or guardian of employee, for medical treatment

Do you (staff member over 18) or your child (parent of staff member 17 or younger) have any medical conditions or restrictions that might limit your or his/ her participation in camp activities?
YES _____ NO _____ If yes, please explain:

Do you (staff-18+) or your child (staff- 17 or younger) have any special needs or disabilities?

Please use this space to provide any additional information about the participant's behavior and physical, emotional or mental health, about which the camp should be aware.

Name of Family Physician: _____Phone: _____

Name of Family Dentist / Orthodontist: _____ Phone _____

**Date of last tetanus shot: _____**

This is especially important in the event of an open wound that needs treatment. Tetanus shots are good for 10 years, unless there is an open wound within 5 to 10 years after the initial immunization.

**Please attach a list and date of Immunizations: (Department of Human Services Requirement)**
Please photocopy a record from school or physician or have your Doctor fax it to us. We need this as an updated form, even if you were at camp last year.

**KNOWN ALLERGIES**:

Medical

Food

Insects/Plants

If you are on any medication, please list in the space provided.

If you must take medication while at camp, you must complete the Medication Consent Form. This will help us to insure your safety as well as the safety of others. All medications must be locked up at camp and dispensed under the supervision of the camp Nurse or Director. **Call the Nichols Day Camp office for this additional medical form, if needed or download it from the NDC Website at www.nicholsdaycamps.org**

**Mail this completed form to:**
**Nichols Day Camp, P.O. Box 472, Blue Hill, ME 04614**