

# Camp Kahoka **STAFF** Application & Health Information

**First Name:** \_\_\_\_\_ **Last Name:** \_\_\_\_\_

**Gender:** Male Female **Birthday:** \_\_\_/\_\_\_/\_\_\_

**Information:**

	Staff	Spouse or Emergency Contact
<b>Employer/Job Title</b>		
<b>Work Phone</b>	( )	( )
<b>Home Phone</b>	( )	( )
<b>Cell Phone</b>	( )	( )
<b>Email</b>		

**Home Address:** \_\_\_\_\_ **CITY/ST/ZIP:** \_\_\_\_\_

**Emergency Contact Person** (if you are not available): \_\_\_\_\_ **Phone:** ( ) \_\_\_\_\_

**INSURANCE INFORMATION:** Primary Policy Holder Name: \_\_\_\_\_

Policy Holder ID: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_/\_\_\_/\_\_\_

ID: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_

**PLEASE ATTACH A COPY OF THE FRONT & BACK OF YOUR INSURANCE CARD.**

Please note here if you do not have insurance: \_\_\_\_\_

**HEALTH HISTORY**

(Check, if applies. Give approximate dates.)

- Frequent Ear Infections
- Heart Defect/Disease
- Convulsions/Epilepsy
- Diabetes
- Bleeding/Clotting Disorders
- Hypertension
- A.D.D./A.D.H.D
- Mononucleosis
- Bedwetting
- Sleepwalking

**DISEASES**

(Check, if applies. Give approximate dates.)

- Chicken Pox
- Measles
- German Measles
- Mumps

**ALLERGIES** (Dates not needed)

- Hay Fever
- Ivy Poisoning, etc. (see below)
- Insect Stings (see below)
- Asthma
- Penicillin
- Other Drugs

**List:**

Is allergy severe enough to keep your child from participating from activities in the woods? Yes \_\_\_ No \_\_\_

*Please notify Camp Kahoka in writing if any of the information on this form changes before camp.*

Family physician \_\_\_\_\_ Phone \_\_\_\_\_ Dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Operations or serious injuries (dates): \_\_\_\_\_

Describe any psychological conditions: \_\_\_\_\_

Disability or chronic recurring illness \_\_\_\_\_

Activities limited by a physician \_\_\_\_\_

Dietary restrictions (Camp Kahoka will not provide special meals, but we will inform our staff of a camper's restrictions and help them choose allowed foods from our regular menu.) \_\_\_\_\_

Applicant is under the care of a physician for the following reasons: \_\_\_\_\_

List any medication to be administered at camp and diagnosis or reason for taking (specific times & doses, use back of application for additional space) \_\_\_\_\_

**PLEASE READ AND SIGN:** I hereby attest that I have read and reviewed this form and have completed it accurately and will report any information that may change. I therefore agree that my child/ward may participate in all camp activities including travel off of the property. Also, I give permission for Camp Kahoka to use images and recordings of my child/ward without further compensation. I realize that in the event of an illness or injury while at camp or while participating in it's activities, medical treatment may be required. I give permission for the medical personnel selected by the camp director to order any medical procedures, including x-rays, routine tests, treatment, hospitalization and transportation. Furthermore, I agree to bear the cost of all such treatment. I also agree to hold harmless Camp Kahoka, it's staff, and volunteers from any and all liabilities, claims, demands and causes of action whatsoever which may arise due to the participation of myself or my child/ward in said activities.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_