

**This confidential application must be completed in FULL and will be returned if incomplete.**

**Full Name:** \_\_\_\_\_ : \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ : \_\_\_\_\_

Mailing Address: \_\_\_\_\_ County: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Group Living Facility (if applicable) \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Sex: M or F (circle) \_\_\_\_\_

Parent/Guardian/Spouse Name: \_\_\_\_\_

Address (if different) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

**Emergency Contacts (Other than above):**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: (\_\_\_\_) \_\_\_\_\_ Night Phone: (\_\_\_\_) \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Day Phone: (\_\_\_\_) \_\_\_\_\_ Night Phone: (\_\_\_\_) \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Health Insurance Carrier: \_\_\_\_\_ Policyholder: \_\_\_\_\_ Policy#: \_\_\_\_\_

	Month/Year		Month/Year		Month/Year
Arthritis		Bleeding Disorder		Chicken Pox	
Ear Infections		Hypertension		Measles	
Heart Defect		Mononucleosis		Rubella	
Diabetes		Decubitis Ulcer		Mumps	

Is the applicant subject to conditions with (circle Yes or No):

Eyes	Y	N	Skin	Y	N	Abdomen	Y	N	Ears	Y	N
Scalp	Y	N	Kidneys	Y	N	Stomach Upset	Y	N	Nose	Y	N
Throat	Y	N	Constipation	Y	N	Lungs	Y	N	Heart	Y	N
Skeletal	Y	N									

Recommendations: \_\_\_\_\_

**SEIZURES:** None \_\_\_\_\_ Petit Mal \_\_\_\_\_ Grand Mal \_\_\_\_\_ Other \_\_\_\_\_

Severity: \_\_\_\_\_ Frequency: \_\_\_\_\_ Most Recent: \_\_\_\_\_

<b>ALLERGIES:</b>	Type	Mild	Severe
Drugs			
Insects			
Pollens			
Foods			
Asthma			

If reaction occurs: \_\_\_\_\_

**IMMUNIZATION HISTORY**

(Write month/year of basic immunization, and most recent booster, or you must write "current, dates unknown" and initial)

	Date		Date		Date
DPT		Rubella		T.B. Test	
Polio		Small Pox		Mumps	
Measles		Tetanus		Hepatitis B	

**SURGERIES/SERIOUS ILLNESS** (give dates): \_\_\_\_\_

**CHRONIC OR RECURRING ILLNESS:** \_\_\_\_\_

**CURRENT PRESCRIPTION MEDICATIONS:**

- 1. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_
  - 2. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_
  - 3. \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_
  - Non-Prescription: \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_
- Activities to be encouraged or limited: \_\_\_\_\_

**STAFF/DIRECTOR APPLICATION**

This Health History is correct to the best of my knowledge, and the applicant described herein may engage in all program activities except as noted. I give permission to the medical personnel selected by the Director to order x-rays, routine tests and treatment for me. I hereby give permission to the physician selected by the Director to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for me. This form may be photocopied for use out of camp.

In consideration for acceptance, I hereby release and waive any claim, cause or action which may accrue against the NORTHWEST KIWANIS CAMP, any employee thereof, or any other persons acting with their permission, arising from injury during his/her work at the KIWANIS CAMP site from said facility, or during any activity approved by any of said persons.

I give my permission and approval, upon being accepted as a staff member at the NORTHWEST KIWANIS CAMP, that any photographs, video or film in which I may appear can be used to benefit the camp.

Signature : \_\_\_\_\_ Date: \_\_\_\_\_