



134 PR 223
 AQUILLA, TEXAS 76622-2582
 PHIL COLQUITT, CEO
 TEL: 254-694-3689
 FAX: 254-694-4174

SUMMER STAFF MEDICAL HISTORY FORM

This form must be completed & returned Summer 2010

This MEDICAL HISTORY FORM must be completed by parent (or guardian) and applicant in order for the staffer to participate in job requirements at Latham Springs Baptist Camp. These questions are designed to determine if the applicant has developed any condition, which would make it difficult to participate in the job assignments.

- | | | |
|--|-------|-------|
| 1. During the past 12 months: | YES | NO |
| a. Was he/she hospitalized? | _____ | _____ |
| b. Did he/she have any injuries requiring medical attention? | _____ | _____ |
| c. Did he/she have any illness lasting more than one week? | _____ | _____ |
- If answered, "yes" to any questions, explain _____

2. Does he/she take medication regularly? _____
- Please list: _____

3. Do you know of any reason why there should be limits in his/her performance? _____
4. Has he/she ever had a concussion or been knocked unconscious? _____
5. Has he/she ever had a convulsion? _____
6. Is he/she now under a doctor's care? _____
7. Is he/she allergic to any medication or chemical? _____

- Please list: _____
8. What year was the last tetanus booster given to applicant? _____

Applicant signature _____ Date _____

Parent or Guardian Statement: In consideration for your agreeing to accept the person named above, I hereby give my authority and consent to medical and surgical treatment as may be needed in the judgment of the treating physician for my child by a physician chosen by the Camp Manager or staff. I also authorize the camp personnel to transport my child at their discretion in case of an emergency.

I have read and understand this medical history and release that my child has signed and promise that all the information that I gave was correct. If any information given above is found to be false, the applicant will be immediately dismissed.

Parent/Guardian signature: _____ Date _____

In case of illness, please complete the following:

Health Insurance Provider _____

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