PARK RIVER
·BIBLE · CAMP·

STAFF HEALTH AND PHYSICAL EXAM FORM

The information contained on both sides of this form is strictly confidential for personnel records of the camp. These are accessible only to the camp director, the medical staff and the camp secretary.

NAME _____ DATE OF EXAM_____

MAILING ADDRESS_____

IN CASE OF MEDICAL EMERGENCY (home phone) _____

_____

(Primary Contact Name & Daytime Phone) (Primary Contact Name & Daytime Phone)

PHYSICIAN'S COMMENTS:

_____Blood Pressure _____ EENT

_____Black Outs _____ Lungs

_____Epilepsy _____ Abdomen

_____Prosthesis _____ Kidney

_____Asthma _____ Hernia

_____Appendix _____Muscular-Skeletal

_____Back _____ Other

_____Allergies: Insects_____ Medications_____

Medications currently being taken: _____

Does the employee have a medical condition or is the employee taking medication that may impair their ability to perform the essential functions of their position. If so, this must be discussed with the Camp R.N.:

_____
_____
_____
_____
_____
_____

_____
Signature of Physician or Camp Nurse Date

106 Solid Rock Circle
Park River, ND
(o) 701.284.6795 (f) 701.284.6796

TO BE FILLED OUT BY THE EMPLOYEE:

FULL LEGAL NAME _____
Last First Middle

SOCIAL SECURITY NO: _____ DATE OF BIRTH_____

INSURANCE PROVIDER AND POLICY #: _____

REGULAR PHYSCIAN OR HEALTHCARE FACILITY & PHONE NUMBER_____
_____

PERMANENT MAILING ADDRESS _____
Street or PO Box

_____
City State Zip Country

PHONE # _____ ALTERNATE PHONE # _____

HEIGHT_____ WEIGHT_____ DO YOU WEAR CONTACTS/GLASSES? _____

HEALTH HISTORY: Mark an "X" for past conditions. Mark a "C" for current conditions. If there is additional information that we should know, please attach a note to this form.

____ Appendicitis ____ Heart Trouble ____ Nervousness ____ Hernia

____ Sinus Trouble ____ Rheumatic Fever ____ Seizures ____ Diabetes

____ Ear Trouble ____ Cramps in Water ____ Fainting Spells ____ Homesickness

____ Asthma ____ Bleeding disorders ____ Date of last Tetanus

ALLERGIES: ____ Hay Fever ____ Aspirin ____ Penicillin

____ Insect Stings-specify_____ ____Medications-specify_____

____Other:_____

DISEASES (list year) ____Chicken Pox ____German Measles ____Mumps
(vaccine, booster, or "had the disease")
____Other:_____

To the best of my knowledge, I am physically able to perform the work involved in the position for which I am applying. I understand that work related accidents are covered by Worker's Compensation of North Dakota. All other insurance needs are my own responsibility.

_____ _____
Signature Date

TO BE SIGNED BY PARENT/GUARDIAN OF STAFF PERSONS UNDER 18 YEARS OF AGE

I/We authorize the assigned staff member of Park River Bible Camp to provide emergency medical care for the person named on this form if any medical emergency should occur while he/she is involved with camp activities. I understand that work related accidents are covered by Worker's Compensation of North Dakota. All other insurance needs are my own responsibility.

_____ _____
Signature Date