Staff Health Form

Surname: _____
Given Name: _____
Date of Birth: (mm/dd/year) _____

Home Address: _____

City: _____ Province: _____

Postal Code: _____

Phone Number: (____) _____

Work: (_____) _____

Insurance Information

Provincial Medical Insurance Number: _____
(MSI, Etc)

Additional Insurance coverage: _____

Emergency Medical Information

Does the applicant have any allergies? ____ (yes) ____ (no)
If yes, please indicate below:

____Medicine ____Insect Bites ____Toxins ____ Food ____ Smoke
____Plants ____Animals
Other: _____

Details:
_____
_____
_____
_____
_____

Has had, please check (x):
____Appendicitis ____Mumps ____Chicken Pox ____Measles
____Kidney Disease ____ Scarlet Fever ____
____Rheumatic Fever ____Heart Condition ____
Others _____

If subject to any of the following, check (x) and give details:
____Asthma ____HIV ____Motion Sickness ____
____Contact Lenses ____Ear Problems ____Cramps
____Hernia ____Headaches ____Diabetes ____
____Convulsions ____Fainting Spells ____Sleepwalking ____
____Bleeding Disorders ____Back Problems ____Nightmares ____
Others _____

Does the applicant require special care, medication or diet?
Details:
_____
_____
_____

Has it ever been necessary to restrict the applicant's activities for medical reason?
____Yes ____ No

Details:
_____
_____

Emergency Treatment Release: I hereby authorize the medical personnel chosen by Atlantic Burn Camp to secure and administer treatment for myself in the event of a medical emergency. This treatment may include, but may not be limited to transportation, x-rays, routine tests and any necessary treatments.

Signature of Applicant:
_____

Date: _____