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: _____