

Camp Brethren Heights
Staff Member Health History Record

Name _____ D.O.B. _____

Street Address _____ Phone (____) _____

City _____ State _____ Zip _____

Personal Physician's Name _____

Address _____

Telephone _____

May we contact your physician regarding your physical condition?

_____ Yes _____ No

Current Health Issues and History

Please list any allergies you have:

List any health problems you have including current infectious diseases:

List any physical limitations:

List any medications you take regularly:

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>
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I certify that this information is true to the best of my knowledge.

Staff Member Signature _____ Date _____