Administrative Camp Director:
Alisa Zitofsky
Camp Iconic Director:
Sara Ardila
Wee Friends Camp & School Director
Linda Zryb

STAFF MEDICAL EXAMINATION FORM

To be completed By Physician, Physician's Assistant, or Nurse Practitioner

Staff Member's Name: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Email Address: _____

Emergency Contact: Name: _____ Relationship: _____ Phone: _____

Tuberculin Test

Date Administered:

_____

Date Read:

_____

Please specify

Tine ☐ Mantoux ☐

Pos ☐ Neg ☐

Results

If positive, please attach physician's statement documenting treatment and follow-up.

Include All Dates
Immunizations

DPT	1st	2nd	3rd	Booster	Booster
ORAL POLIO	1st	2nd	3rd	Booster	Booster
COVID-19	1st	2nd		Booster	
MMR	1st	2nd			

Other

Type	Date
Type	Date
Type	Date

On the basis of my findings and on my knowledge of the above named individual, I find that his/her health is satisfactory to provide child care at camp. ( ) yes ( ) no
He/she is free from communicable disease. ( ) yes ( ) no
He/she is physically and mentally fit to provide child care at camp. ( ) yes ( ) no
Medical or Developmental Concerns: None _____Yes: (specify) _____
_____
Meds needed during work hours: None: ___ Yes (specify) _____
Allergies: None known ____ Yes (specify) _____
Signature of Examiner: _____ Complete Address: _____
Name (please print): _____ _____
Title: _____ _____
Date: _____ Phone: _____