Staff Registration Form

☐ Counselor ☐ Kitchen/Maintenance
☐ Other_____

Camps Working (please circle):
All Camps Primary I Primary II Junior I Junior II Jr. High H.S. Discipleship Weekends

Staff Name | Staff Email | M / F Gender

Staff Address | City | State | Zip Code

( ) Staff Home Phone | ( ) Staff Cell Phone | Age | Birthday | Years at Camp

Home Church | Church Address | City | State | Zip

Certifications (circle): Lifeguard CPR/First Aid Serve Safe RN Other: _____
Please provide proof of each certification

Emergency Contact | Relationship

( ) Emergency Contact Home Phone | ( ) Emergency Contact Cell Phone

( ) Secondary Emergency Contact | Relationship | Phone

PHOTO CONSENT: *Mountain Meadows Bible Camp uses pictures from the week to make DVD's of slide shows and may use pictures in printed/web publications. Your registration constitutes permission for Mountain Meadows Bible Camp to use images for those purposes. A written statement must be on file if you do not give consent.*

Authorization of Treatment

I/We (parent/guardian) do hereby authorize Mountain Meadows Bible Camp as agents for the undersigned to administer my child's prescribed and over the counter medications as indicated by a physician and/or myself. I further consent to any x-ray examinations, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice Act on the medical staff or licensed hospital. I understand that every effort will be made to contact me in the event of an emergency.

Date

Signature of Staff (if over age 18) **If staff member is under age 18, parent/guardian signature is required.**

Date

Signature Parent/Guardian

Medical/Health History

Confidential

Personal Health and Accident Insurance	
Policy Number	
Personal Physician	
Phone Number	
Mt. Meadows accidental insurance is a secondary coverage. In the event of an accident, your insurance will be billed first.	

Please check YES or NO on the following	YES	NO
Able to swim- -	☐	☐
Immunizations current - - - - - - - - - - - - - - - - - -	☐	☐
Date of last Tetanus Vaccine_____		
Any activity restrictions for medical reasons?*- -	☐	☐
Allergies to food/medicine*- - - - - - - - - - - - - - -	☐	☐
Special Dietary Needs*- - - - - - - - - - - - - - - - - -	☐	☐
Condition requiring medication*- - - - - - - - - -	☐	☐

*If yes to these questions above, please include attachment with further explanation of needs.

Health History: (Circle those that apply)

Diabetes	Anaphylaxis	Frequent Urination
Asthma	Iodine allergy	Heart Problems
Ear Infections	Epilepsy/Seizures	Other:

All medications must be turned in to the camp nurse for distribution. Please fill out the Medication Form if you bring medication from home. Please check the boxes below for permission to administer over the counter medications as needed.

Please check YES or NO for each medication

YES	NO		YES	NO	
☐	☐	Pepto Bismol *(upset stomach)*	☐	☐	Cough drops
☐	☐	Ibuprofen *(head/muscle aches)*	☐	☐	Tylenol *(head/ muscle aches)*
☐	☐	Benadryl *(itching cold/allergy symptoms)*	☐	☐	Neosporin *(cuts/scrapes)*
☐	☐	Caladryl cream *(itching/bug bites)*	☐	☐	Tums *(upset stomach)*

ALL MEDICATIONS and PRESCRIPTIONS MUST:
1. Be in the original container.
2. Have a note with HOW, WHEN, and WHY to administer which is SIGNED by the legal guardian.

OFFICE USE ONLY
Recent exposure to pink eye, flu, other infections?
Feeling sick?