**Administrative Camp Director:**
Alisa Zitofsky
**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 | Booster | 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: _____