



# Massachusetts Junior Conservation Camp

A project of the Massachusetts Sportsmen's Junior Conservation Camp Inc.

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Phone: 508-450-5120 Email: MAJuniorCamp@gmail.com

Website: www.juniorconservationcamp.org

Name	Age	Sex
Address	Date of Birth	Phone

## Employee Health Record

Please indicate whether you have ever had the following:

- |             |  |                 |  |
|-------------|--|-----------------|--|
| Asthma      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles, German | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chicken Pox | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cramps      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fainting    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay Fever   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sleepwalking    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Indigestion | <input type="checkbox"/> Yes <input type="checkbox"/> No | Operations      | _____  |
| Measles     | <input type="checkbox"/> Yes <input type="checkbox"/> No |                 |  |

Please check if you have sensitivity to the following:

- |                |  |                          |  |
|----------------|--|--------------------------|--|
| Bronchitis     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Poison Ivy, Oak or Sumac | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Colds          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Infections         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Convulsions    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Sore Throat              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ear Infections | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach Upsets           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other                    | _____  |

Please list any concerns, medical or otherwise, which our Camp Director/Camp Nurse should be aware of \_\_\_\_\_

## INSURANCE INFORMATION

Name of Subscriber \_\_\_\_\_

Relationship to Employee \_\_\_\_\_

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_