Camp Auxilium Staff Health Form

Name	Date
Position	
Address	
City	State Zip
Phone	Cell
Emergency Contact Person:	
Emergency Contact Phone:	

Health History/Health History Update

Any medications currently being taken
Current or recent health problems
Past serious illnesses and injuries
Allergies EPI Pen required? YES NO
Any sight or hearing problems

Date of last physical	Date of last tetanus
Name of family physician	
Phone of family physician	
Date of last TB test	Type Result

I am both physically and mentally fit to perform the duties required for the position requested, and pose no health risks to students or other employees. I further certify that the above information is correct to the best of my knowledge and belief. In the event that, due to accident, illness, or injury, I become unable to determine my own medical care, I give permission for the Camp Director, or her delegate to secure proper treatment for me.

Signature	Date

HEPATITIS B VACCINATION STATEMENT

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given information on the Hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated.

❑ **OPTION 1**

_____ has completed the following inoculations:
(name of employee)

Hepatitis B Vaccine

Inoculation 1: Date _____ Given at

Inoculation 2: Date _____ Given at

Inoculation 3: Date _____ Given at

OR See attached medical form for more information.

❑ **OPTION 2**

I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I should receive the vaccination at my own cost and will provide updated information for my medical file.

❑ **OPTION 3**

Information is on file from previous year.

Please check one of the above options, then sign and date below:

Applicant Name (please print)_____

Applicant Signature _____

Date_____