



Jõekäärü Suvekodu Selts / Estonian Camp Udora, Inc.

Jõekäärü Laste Suvekodu

EMPLOYEE MEDICAL FORM

(to completed and signed by parent or legal guardian if underage)

Name of employee: _____ Date of Birth _____ Age: _____

Address: _____

Home # _____ work # _____ cell #: _____

Health Card: _____

Other Insurance: _____ Name of Carrier: _____

Family Doctor: _____ Tel#: _____

Responsible contact to be notified if you must be unavoidably transferred from camp:

Name _____ home tel#: _____ work tel#: _____

Check only if "yes"

<u>Have you had:</u>	<u>Are you subject of:</u>	<u>Do you have:</u>	<u>Explain</u>
<input type="checkbox"/> chickenpox	<input type="checkbox"/> tonsillitis	<input type="checkbox"/> heart disease	_____
<input type="checkbox"/> scarlet fever	<input type="checkbox"/> earache	<input type="checkbox"/> epilepsy	_____
<input type="checkbox"/> red measels	<input type="checkbox"/> fainting	<input type="checkbox"/> diabetes	_____
<input type="checkbox"/> german measels	<input type="checkbox"/> abdominal pain	<input type="checkbox"/> bee sting allergy	_____
<input type="checkbox"/> mumps	<input type="checkbox"/> headaches	<input type="checkbox"/> insect allergy	_____
<input type="checkbox"/> whooping cough	<input type="checkbox"/> sleep walking	<input type="checkbox"/> penicillin allergy	_____
<input type="checkbox"/> hepatitis	<input type="checkbox"/> bed wetting	<input type="checkbox"/> other drug allergy	_____
<input type="checkbox"/> diphtheria	<input type="checkbox"/> summer cough	<input type="checkbox"/> a special diet	_____
<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> hay fever	<input type="checkbox"/> special medication	_____
<input type="checkbox"/> _____	<input type="checkbox"/> eczema	<input type="checkbox"/> asthma	_____

<u>Full immunization</u>	<u>Date of the latest booster</u>	<u>Comments on above history</u>
<input type="checkbox"/> tetanus	tetanus tozoid _____	_____
<input type="checkbox"/> poliomyelitis	polio vaccine _____	_____
<input type="checkbox"/> diphtheria	diphtheria _____	_____
<input type="checkbox"/> pertussis	pertussis _____	_____
<input type="checkbox"/> red measles		_____
<input type="checkbox"/> rubella		_____
<input type="checkbox"/> mumps		_____

Covid-19 Vaccination Date(s): _____

HEIGHT: _____ WEIGHT: _____

May you go in the water? YES NO

Please provide any other information which may be helpful to the medical personnel:

If I become exposed to an infectious disease just prior to coming to camp, I will notify the director.

I hereby grant permission that I may be taken to an available medical doctor or hospital for treatment should it be required. To the best of my knowledge I am in good health, free from communicable diseases, and am fit to participate in camp activities, except as previously indicated.

The undersigned covenants and agrees to indemnify, defend and save harmless the Estonian Camp Udora Inc. and/or its employees from and against all claims, actions and suits whether groundless or otherwise and from and against all liabilities, losses, damages, costs, charges, council fees and other expenses of every nature arising directly or indirectly out of or in consequence of by reason of or as a result of any inadvertence, accident, oversight or neglect.

Date: _____

Signature (self or parent/legal guardian if underage): _____