



FC Georgia Camp-Staff Medical Form

Note: Once you have been officially selected as Counselor or Staff position, please complete the form below.

Name: _____ DOB: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

***Please complete this form and return with a photocopy of your medical card.
All information will be kept confidential.***

YES NO Have you been hospitalized or treated by a physician within the last year?
If yes, why? _____

YES NO Have you had a tetanus shot within the last 5 years?

YES NO Do you have any known allergies? (Example: food, medicines, pollen, etc.)
If yes, what? _____

YES NO Will you be on any prescription medicines at camp:
If yes, what: (include dosage) _____

YES NO Are you taking any over-the-counter medicines on a regular basis?
If yes, what and how often? _____

I hereby authorize the camp nurse or physician, nurses an assistants of the local hospital or emergency service to perform all treatment and procedures as ordered or deemed necessary in the case of emergency to the individual listed above.

Applicant's Signature: _____ Date: _____

Emergency Name and Phone Number: _____

I FOR MYSELF AND ON BEHALF OF MY HEIRS, ASSIGNS, PERSONAL REPRESENTATIVES AND NEXT OF KIN, HEREBY RELEASE INDEMNIFY, AND HOLD HARMLESS FC GEORGIA CAMP, THEIR OFFICERS, OFFICIALS, AGENTS, AND /OR EMPLOYEES, OTHER PARTICIPANTS, SPONSORING AGENCIES, SPONSORS, ADVERTISERS, AND IF APPLICABLE, OWNERS AND LESSORS OF PREMISES USED TO CONDUCT THE EVENT (RELEASEES), WITH RESPECT TO ANY AND ALL INJURY, DISABILITY, DEATH, OR LOSS OR DAMAGE TO PERSON OR PROPERTY. WHETHER ARISING FROM THE NEGLIGENCE OF THE RELEASEES OR OTHERWISE, TO FULLEST EXTENT PERMITTED BY LAW.

Applicant's signature _____