

# STAFF EMERGENCY INFORMATION CARD

IMPORTANT --- PLEASE PRINT AND COMPLETE BOTH SIDES

This information must be completed for acceptance --- MUST be returned with application

Employee Name \_\_\_\_\_ Nickname \_\_\_\_\_  
(Full legal name) Last First Initial

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Circle: 4/5 or Full Day Group # \_\_\_\_\_ SS# \_\_\_\_\_ Birth Date \_\_\_\_\_

Contact Person \_\_\_\_\_

Contact Person \_\_\_\_\_

Home Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work /Pager \_\_\_\_\_

Work /Pager \_\_\_\_\_

Relationship to employee \_\_\_\_\_

Relationship to employee \_\_\_\_\_

## Additional emergency contact persons:

Emergency Name \_\_\_\_\_

Emergency Name \_\_\_\_\_

Home Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

Tenacre Day Camp must comply with regulations of the Massachusetts Department of Public Health (105 CMR 430) and be licensed by the Wellesley Board of Health. Information on these regulations can be obtained at (617) 983-6761.

**PLEASE COMPLETE REVERSE SIDE**

LIST ALL ALLERGIES (describe reaction to & management of each)

Do you have an EpiPen?  Yes  No

Do you have any chronic or recurring medical problems? Please describe: \_\_\_\_\_

PLEASE INITIAL over-the-counter medications the nurse may administer at camp per *standing care orders*:

Tylenol \_\_\_\_\_ Motrin / Ibuprofen \_\_\_\_\_ Benadryl \_\_\_\_\_ Calamine Lotion \_\_\_\_\_ Other (list) \_\_\_\_\_

Is there any other information that should be shared? \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist/Orthodontist Name \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Carrier \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Primary Subscriber's Name \_\_\_\_\_

**Employee Authorization:** I hereby give permission to release the Emergency Information Card, Physician's and Health History forms to the medical personnel selected by the camp administration to order x-rays, routine tests, treatment, injections; to release any records necessary for insurance or medical purposes; and to provide or arrange necessary related transportation for myself. I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, order injections, anesthesia and/or surgery for myself. This completed form may be photocopied.

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