

**YOUTH CAMP HEALTH HISTORY**  
**STAFF MEMBER/VOLUNTEER**

Name: \_\_\_\_\_

Current residence: \_\_\_\_\_

\_\_\_\_\_

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician or  
other provider of medical care: \_\_\_\_\_

HEALTH INFORMATION:

Are there any pertinent health problems including physical, psychiatric, or behavioral problems of which we need to be aware?       NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware?       NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATION INFORMATION:  
**Must list current residence above.**

For staff members/volunteers who currently reside **within** the United States, a United States territory, or the District of Columbia: Do you have any immunization exemptions because of a parental or guardian objection or medical contraindication?       NO

YES, List: \_\_\_\_\_

For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form MDH-896.

\_\_\_\_\_  
Staff Member/Volunteer Signature or  
Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years)  
MDH-4767 (12/2017)

\_\_\_\_\_  
Date