1984 Enterprises Inc
STAFFING • FIRST AID • SAFETY

VOLUNTARY PERSONAL MEDICAL INFORMATION SHEETS

Employer: _____

VOLUNTARY PERSONAL MEDICAL INFORMATION

Please complete the requested information. Provide as much detail as possible. Medical information is confidential and can only be accessed by the medical team. The information you provide will precipitate your needs for care in the event of an injury.

PERSONAL INFORMATION		
Name	Phone Number	
Address		
City/Town	Province/Territory	Area Code
Date of Birth (MM/DD/YYY)	What Blood Type Are You	Gender ❑ Male ❑ Female
Next of Kin	Relationship	Contact Number

MEDICAL INFORMATION	
Any current inoculations?	Hepatitis B ❑ + Tetanus ❑
Do you have Heart Disease?	❑ YES ❑ No
Do you have Diabetes?	❑ YES ❑ No ❑ *Type 1* ❑ *Type 2*
Do you wear contact lenses?	❑ YES ❑ No
Do you have allergies?	❑ YES ❑ No *If yes, please fill in space provided what you are allergic to and the reaction.*
Are you taking any medications prescribed by a doctor?	❑ YES ❑ No *If yes, please fill in space provided the name of the drug as well as the dosage.* Name of drug Dosage

Signature: _____ Date: _____

You consent to the collection, use or disclosure of personal information. If you require more information regarding our privacy policy refer to appropriate section in the camp manual or visit www.1984inc.com