

# Michigan Region Missionary Church

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## EMPLOYEE HEALTH HISTORY RECORD MICHIGAN DEPARTMENT OF SOCIAL SERVICES

### Employee Information

Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

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

Email: \_\_\_\_\_

### Camp Info

Which Camp(s) do you plan to serve?

HAPPY TIME CHILDREN'S CAMP \_\_\_\_\_

MANCELONA YOUTH CAMP \_\_\_\_\_

BROWN CITY YOUTH CAMP \_\_\_\_\_

In what capacity? COUNSELOR \_\_\_\_\_ OTHER STAFF POSITION \_\_\_\_\_

### Medications Needed or Used (including psychiatric)

	Type of Medication	Frequency Taken	Dosage	Currently Being Taken
1.				
2.				
3.				
4.				

### Information

Are there any special conditions to be watched for such as allergies to foods, drugs, insect bites/stings, etc.? If so, please list allergies or conditions and include any instructions that would be helpful if a problem arises: \_\_\_\_\_

Have you recently been exposed to any infectious disease? No \_\_\_ Yes \_\_\_ If yes, please explain: \_\_\_\_\_

Are you restricted from any activity because of physical defect or illness? No \_\_\_ Yes \_\_\_ If yes, please explain the degree of restriction: \_\_\_\_\_

### Signature

To the best of my knowledge, I certify that the above information is true:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by Health Officer: \_\_\_\_\_ Date: \_\_\_\_\_