

# Michigan Region Missionary Church

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## STAFF 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: _____				