

STAFF HEALTH HISTORY

EMPLOYEE LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH (MM/DD/YYYY)
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HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE NUMBER
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PERMANENT ADDRESS (OR PARENTS)	CITY	STATE	ZIP CODE	PHONE NUMBER
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SOCIAL SECURITY NUMBER	NAME OF INSURANCE CARRIER	ADDRESS	POLICY NUMBER
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EMERGENCY CONTACT INFORMATION:

FIRST CONTACT: _____ PHONE: _____ CELL: _____

ALTERNATE: _____ PHONE: _____ CELL: _____

ALLERGIES – Please list any allergies to medications, foods, insect stings or environmental stimuli. PLEASE describe the reaction you have when exposed to these allergens. Make special note of any anaphylactic reactions – those that require an EPI Pen.

MEDICATIONS – Please list ALL medications you take daily. We ask for a list of your medications here in case of emergency. This information is kept confidential amongst the medical staff at camp. Attach another sheet if necessary.

Medication	Dose	Frequency (how often a day)
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHRONIC HEALTH STATES – Please check all that apply. Attach a separate note to describe any condition that requires special attention by the health care team at camp.

- I have no chronic health concerns.
- I have the following chronic health concerns:
 - Asthma or Allergies Seizure Condition Diabetes
 - Headaches Sleep Problems Back Pain or Injury
 - Knee or Ankle Weakness Surgery in the last year Fainting or Dizziness
 - Frequent Colds / Infections Menstrual Disturbances
 - Gastrointestinal Disturbances Heart or Heart Rhythm Disturbances
- Are there any other health concerns of which you would like us to be aware?

PRIMARY HEALTH CARE PROVIDERS – Please provide the names and phone numbers of your home physicians.

Primary Care _____ Phone _____
Orthodontist _____ Phone _____
Dentist _____ Phone _____
Mental Health Provider _____ Phone _____

WHAT HAVE WE FORGOTTEN TO ASK? Please provide any additional information about your health, which was not discussed on this form. Attach another sheet as necessary.

PAYING FOR HEALTHCARE:

- There is usually no cost for healthcare provided by the camp’s healthcare team (Physician and Registered Nurses), except for medications prescribed for you by the physician at camp. (e.g. Antibiotics for strep throat, etc.)
- Staff members are financially responsible for healthcare provided by out-of-camp providers such as dentists.
- You are responsible for knowing how to access your health insurance while working at Camp. Bring your insurance ID card with you as well as attaching a photocopy to this form. Obtain pre-authorization for out-of-state use if your insurance requires this.
- **CANADIAN STAFF** – Please note that healthcare in the United States is very different than in Canada. Your provincial health care plans are NOT accepted at the local hospitals. For your own financial safety, obtain Travel Health Insurance before you leave for Camp. Blue Cross / Blue Shield is recommended.

AUTHORIZATION FOR HEALTHCARE

Parent signature is only required for staff under 18 years of age.

This health history is correct as far as I know. I declare that I am capable of performing the essential functions of my job and that I am able to participate in assigned activities except as noted on this form. I understand my health information will be used by Camp’s healthcare staff in providing care to me and may be reviewed by the camp directors.

I understand that I am financially responsible for all medications; any medically required examinations or diagnostic tests prescribed for me. I authorize Camp to release any records necessary for insurance purposes and to obtain my health information from other providers when it pertains to my immediate care.

In the event of an emergency where I am unable to give consent, I hereby give permission to the physician selected by Camp to hospitalize, secure proper treatment for, and to order injection anesthesia, or surgery for me.

Signature

Date

Printed Name

Signature of Parent (if employee is under 18 years of age)

Date

Name of Employee _____

Date of Birth _____

Dear Medical Provider,

You are being asked to recommend an employee for participation in a ____ week, sleep-away children’s summer camp program. The campus is hilly and with few paved walkways. Physical demands of staff usually require much walking during daylight, dusk and nighttime visibility. Physical endurance requirements vary on job role and function, but most staff should be able to walk 1-2 miles carrying 10-15 pounds without need for rest. Lifeguards will be expected to be able to swim 200 yards in under 10 minutes. Sports and activity staff will need to perform athletically per their sport, which usually entails running, quick turning / pivoting and jumping. If you require any further information about Camp or our program before making a recommendation for this employee to participate, please feel free to contact us at: _____

IMMUNIZATION HISTORY – Please provide the month and year for each immunization or attach another sheet.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
Diphtheria, Tetanus, Pertussis - DTP				
Booster: Tetanus, Diphtheria, Acellular Pertussis - Tdap		Must be current within last 5 years		
Meningococcal Vaccine (when recommended by your doctor)		Usually given at 11-12 years of age		
Measles, Mumps, Rubella - MMR			2 doses required for camp	
Pneumococcal Polysaccharide Vaccine - PPV				
Inactivated Poliovirus - IPV / OPV				
Hepatitis A - HepA				
Hepatitis B - HepB				
Haemophilus influenza, type B - Hib				
Varicella - VZ				
Tuberculosis Skin Test - TB indicate positive or negative				

BASELINE DATA

Weight _____ Height _____ Temperature _____ Heart Rate _____ Resp. Rate _____ Blood Pressure _____

MEDICAL RECOMMENDATION

Based on the information presented to me and upon my examination of this person, I recommend him or her for camp participation. To the best of my knowledge, he or she has not been exposed to a communicable disease within the last 30 days of my examination.

Signature _____

Date _____

Printed Name _____

Phone _____

Address _____