



HEALTH HISTORY FOR STAFF ATTENDING CAMP

The information on this form is not part of the staff acceptance process, but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors. Update required annually.

Name Last	First	M.I.	Birth Date	Age at Camp
Home Address			City	State Zip
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female				
Emergency Contact			Relationship	
Address			City	State Zip
Business Address	City	State	Zip	Phone
Custodial Parent/Guardian (If staff is a minor)			Phone	
Address (If different than home address above)			City	State Zip
Business Address	City	State	Zip	Phone
Insurance Information: Are you / is staff person covered by medical / hospital insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Carrier or Plan Name			Group #	
Insurance Phone/Contact Number				
Please enclose a copy of your Insurance Card (REQUIRED) <input type="checkbox"/> Done				

Important – This box must be completed for attendance

If completing form online, print form and sign in ink below.

This health history is correct and complete as far as I know. The person named herein has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medication, and emergency treatment for myself or my child, as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization. I also give permission for the camp to arrange related transportation. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is my intention that the camp be treated as acting *in loco parentis* if the above named person is a minor. Further, it is my intention that the appropriate representatives of the camp be treated as "personal representative" for the purposes of disclosing protected health information pursuant to the privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996. I hereby agree (pursuant to 45 CFR § 164.510(b)) to the disclosure to camp representatives of the protected health information of the person herein described, as necessary: (i) to provide relevant information to the camp representatives related to the person's ability to participate in camp activities; and (ii) in the case of minors, to provide relevant information to the camp representatives to keep me informed of my child's health status.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of self (if over 18 years old) or parent / guardian (if under 18 years old)

_____ Date _____

Printed Name _____

HEALTH HISTORY

The following information must be filled in by the parent / guardian or adult staff. The intent of the information is to provide camp health care personnel the background to provide appropriate care. Provide complete information so that the camp can be aware of your needs. Any changes to this form should be provided to the camp health personnel upon the participant's arrival to camp.

ALLERGIES (List all known)

No known allergies

Medication Allergies

Describe reaction and management of reaction.

Food Allergies

Describe reaction and management of reaction.

Other Allergies (includes latex, insect stings, hay fever, asthma triggers, animal dander, etc.)

Describe reaction and management of reaction.

MEDICATIONS BEING TAKEN

Please list **ALL** medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging / bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

This person takes medications as follows:

Med #1

Dosage

Specific times taken each day

Reason for taking

Med #2

Dosage

Specific times taken each day

Reason for taking

Med #3

Dosage

Specific times taken each day

Reason for taking

Attach additional pages for more medications.

Please identify any medications taken during the school year (if staff is a minor) that the camper does / may not take during the summer:

RESTRICTIONS (the following apply to this individual)

Dietary Restrictions

Does not eat red meat

Does not eat pork

Does not eat eggs

Does not eat poultry

Does not eat seafood

Does not eat dairy products

Other (describe)

Activity Restrictions

MENTAL and EMOTIONAL HEALTH INFORMATION (Answer this section referencing the essential functions of your camp job)

- Do you have an emotional health concern that will impact your work? Yes No
- Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder that will impact your work? Yes No
- Do you have an eating disorder that will impact your work? Yes No
- Do you have a learning challenge that will impact your work? Yes No

If you marked "Yes" to any questions in this section attach a statement that:

- a. Describes the concern and your management plan while working at camp; and
 - b. Describes the support needed from your work supervisor to complement your plan.
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GENERAL QUESTIONS (explain "yes" answers below)

Has the staff member:

1. Had any recent injury, illness or infectious disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Ever had chest pain after / during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have a chronic or recurring illness / condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Ever had high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	15. Ever been diagnosed with a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Ever had a cardiac arrhythmia? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have an orthodontic appliance being brought to camp? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Ever had a head injury or been knocked unconscious? <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Have any skin problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Wear glasses, contacts, or protective eyewear? <input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have diabetes? <input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2 <input type="checkbox"/> Yes <input type="checkbox"/> No
8. Ever had frequent ear infections? <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Ever passed out or been dizzy after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	21. Have back or joint problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
10. Ever had seizures? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. If female, have an abnormal menstrual history <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have problems with diarrhea / constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. Have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Please explain any "yes" answers below, noting the number of the questions.

Which of the following has the staff member had?
 Measles Chicken Pox Mumps Hepatitis A Hepatitis B Hepatitis C
Please give all dates of immunizations

Vaccine	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
TDaP (tetanus/diphtheria/pertussis)				Influenza
HPV				Pneumococcal
Tetanus				TB Mantoux Test; Date of last test Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
MMR				
Hepatitis A				
Hepatitis B				
Varicella (chicken pox)				
Additional information / notes				

Use this space to provide any additional information about the camper's behavior, physical, emotional, or mental health about which the camp should be aware.

Name of Staff Member's Physician	Phone
Physician's Address	City State Zip
Name of Staff Member's Dentist / Orthodontist	Phone
Dentist / Orthodontist's Address	City State Zip

