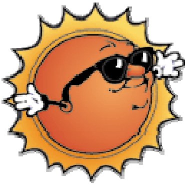

C.W. POST SUMMER DAY CAMP
STAFF HEALTH FORM 2009

THE FOLLOWING FORM MUST BE COMPLETED BY THE STAFF MEMBER AS WELL AS SIGNED BY THE STAFF MEMBER'S PHYSICIAN. THIS INFORMATION PROVIDES CAMP HEALTH CARE PERSONNEL THE BACKGROUND NEEDED TO PROVIDE APPROPRIATE CARE TO EACH STAFF MEMBER. ANY CHANGES TO THE INFORMATION PROVIDED BELOW SHOULD BE GIVEN TO CAMP HEALTH PERSONNEL UPON PARTICIPANT'S ARRIVAL AT CAMP. PLEASE PROVIDE COMPLETE AND ACCURATE INFORMATION.

STAFF INFORMATION

NAME: ____
Last First Middle

BIRTH DATE: _____ / _____ / _____ AGE WHILE AT CAMP: _______________ GENDER: ☐ Female ☐ Male

HOME ADDRESS: ____
Street City State Zip

SOCIAL SECURITY NUMBER OF PARTICIPANT: _________ - ______ - ___________

EMERGENCY CONTACT INFORMATION

CUSTODIAL PARENT / GUARDIAN NAME: ____
Last First Middle

ADDRESS: ____
Street City State Zip

DAYTIME PHONE: (____) _________________ EVENING PHONE: (____)_________________ CELL PHONE: (____)_____________

SECOND PARENT / GUARDIAN NAME: ____
Last First Middle

ADDRESS: ____
Street City State Zip

DAYTIME PHONE: (____) _________________ EVENING PHONE: (____) _________________ CELL PHONE: (____)______________

IF PARENTS / GUARDIANS LISTED ABOVE ARE NOT AVAILABLE IN AN EMERGENCY, CONTACT:

____
Last First

ADDRESS: ____
Street City State Zip

DAYTIME PHONE: (____) _________________ EVENING PHONE: (____) _________________ CELL PHONE: (____)______________

RELATIONSHIP____

NAME OF STAFF MEMBER'S PHYSICIAN: ___________________ PHONE NUMBER: (____)_________________________

ADDRESS: ____
Street City State Zip

IS THE STAFF MEMBER COVERED BY FAMILY MEDICAL / HOSPITAL INSURANCE? Yes ☐ No ☐

CARRIER OR PLAN NAME: _________________________ ID NUMBER: _______________________________________

PHOTOCOPY OF FRONT AND BACK OF HEALTH INSURANCE CARD MUST BE ATTACHED TO THIS FORM.

STAFF MEMBER'S HEALTH HISTORY
TO BE COMPLETED BY PHYSICIAN

	YES	NO
1. RECENT INJURY, ILLNESS, OR INFECTIOUS DISEASE	☐	☐
2. CHRONIC OR RECURRING ILLNESS OR CONDITION	☐	☐
3. BEEN HOSPITALIZED	☐	☐
4. SURGERY	☐	☐
5. FREQUENT HEADACHES	☐	☐
6. HEAD INJURY	☐	☐
7. WEARS GLASSES, CONTACTS, OR PROTECTIVE EYEWEAR	☐	☐
8. FREQUENT EAR INFECTIONS	☐	☐
9. FAINTED DURING OR AFTER EXERCISE	☐	☐
10. SEIZURES	☐	☐
11. CHEST PAIN DURING OR AFTER EXERCISE	☐	☐
12. HIGH BLOOD PRESSURE	☐	☐
13. DIAGNOSED WITH A HEART MURMUR	☐	☐
14. BACK PROBLEMS	☐	☐
15. DIABETES	☐	☐
16. ASTHMA	☐	☐
17. DIARRHEA / CONSTIPATION	☐	☐
18. EATING DISORDER	☐	☐
19. IF FEMALE, HAS THE CAMPER MENSTRUATED	☐	☐
20. EMOTIONAL DIFFICULTIES FOR WHICH PROFESSIONAL HELP WAS SOUGHT	☐	☐

***PLEASE EXPLAIN ANY "YES" ANSWERS, NOTING THE NUMBER ON A SEPARATE SHEET OF PAPER.**

PLEASE MARK IF CAMPER HAS HAD:

☐ MEASLES
☐ CHICKEN POX IMMUNIZATION___________________
☐ GERMAN MEASLES
☐ MUMPS
☐ HEPATITIS
☐ TB TEST RESULTS AND DATE: ______________________

DATE OF LAST IMMUNIZATION:

__ / ___ / __ DTP
__ / ___ / __ TETANUS / DIPHTHERIA
__ / ___ / __ TETANUS
__ / ___ / __ POLIO
__ / ___ / __ MEASLES
__ / ___ / __ RUBELLA
__ / ___ / __ HEPATITIS B
__ / ___ / __ TB
__ / ___ / __ HAEMOPHILUS INFLUENZA B

PLEASE ANSWER THE FOLLOWING QUESTIONS AND ATTACH ADDITIONAL PAGES IF NECESSARY

PLEASE PROVIDE INFORMATION REGARDING PARTICIPANT'S PHYSICAL, EMOTIONAL, OR MENTAL HEALTH WHICH C.W. POST SUMMER DAY CAMP HEALTH STAFF SHOULD BE AWARE OF ____

LIST ALL MEDICATION(S) AND USE. MEDICATIONS BROUGHT TO CAMP MUST BE IN THE ORIGINAL PACKAGING THAT IDENTIFIES THE PRESCRIBING PHYSICIAN, THE NAME OF THE MEDICATION, THE DOSAGE, AND THE FREQUENCY OF ADMINISTRATION (attach an additional page if necessary).
____

DESCRIBE AND EXPLAIN ANY ACTIVITY RESTRICTIONS: ____

DESCRIBE AND EXPLAIN ANY DIETARY RESTRICTIONS:____

LIST ALL KNOWN ALLERGIES. DESCRIBE REACTION AND MANAGEMENT OF THE REACTION (attach another page if necessary)

____

I EXAMINED THIS INDIVIDUAL ON _____________

HEIGHT_________ WEIGHT_________ B.P.________ INDIVIDUAL CAN PARTICIPATE IN ALL CAMP ACTIVITIES ______YES ______NO

***IF ANSWER IS NO PLEASE INDICATE EXPLANATION ON A SEPARATE PIECE OF PAPER**

PHYSICIAN'S NAME_____________________________________ ADDRESS & OFFICE STAMP____________________________________

SIGNATURE OF PHYSICIAN___________________________________ DATE___________________________

THE HEALTH HISTORY DESCRIBED ABOVE IS CORRECT, AND THE CAMPER DESCRIBED HAS PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES EXCEPT AS NOTED.
I HEREBY GIVE PERMISSION TO THE CAMP, CAMP MEDICAL STAFF, AND CAMP STAFF TO PROVIDE ROUTINE HEALTH CARE, ADMINISTER PRESCRIBED MEDICATIONS, AND SEEK EMERGENCY MEDICAL TREATMENT INCLUDING X-RAYS AND ROUTINE TESTS.
I HEREBY GIVE C.W. POST SUMMER DAY CAMP PERMISSION TO TAKE MYSELF TO ANY HOSPITAL FACILITY OR OUTSIDE DOCTOR WHEN DEEMED NECESSARY. FURTHERMORE, I HEREBY GIVE PERMISSION TO SUCH HOSPITAL OR OUTSIDE DOCTOR TO AUTHORIZE X-RAYS AND EMERGENCY TREATMENT IF DEEMED NECESSARY. I UNDERSTAND THAT ALL MEDICAL BILLS FOR SERVICES RENDERED BY ANYONE OTHER THAN THE CAMP'S MEDICAL STAFF ARE MY RESPONSIBILITY. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION OR RECORDS RELATED TO THE TREATMENT, REFERRAL, BILLING, OR INSURANCE PURPOSES RELATED TO MYSELF.

SIGNATURE OF STAFF MEMBER: ____ DATE: ______________________