

2011 CAMP HEBRON STAFF HEALTH AND MEDICAL FORM

This side and the top of the reverse side are to be completed by the staff member (if staff member is under 18 years of age, this form should be completed by parent/guardian). The reverse side, lower portion, is to be completed through your physician's or health services office.

NAME _____ SEX _____ AGE _____
 ADDRESS _____
 BIRTHDATE _____ HEIGHT _____ WEIGHT _____ PHONE (____) _____

EMERGENCY CONTACTS: (PLEASE FILL IN ALL 3 NAMES)

1. PARENTS/GUARDIANS: _____ DAYTIME PHONE (____) _____
 RELATIONSHIP TO YOU: _____ EVENING PHONE (____) _____ CELL/PGR(____) _____
 2. RELATIVE/GUARDIAN: _____ DAYTIME PHONE (____) _____
 RELATIONSHIP TO YOU: _____ EVENING PHONE (____) _____ CELL/PGR(____) _____
 3. IF ABOVE UNAVAILABLE, CONTACT: _____ DAYTIME PHONE (____) _____
 RELATIONSHIP TO YOU: _____ EVENING PHONE (____) _____ CELL/PGR(____) _____

HEALTH HISTORY

Indicate below if you or your family have had any history of the following (indicate Y=yes, N=no, S-self, or R-relation, & approximate dates).
 Elaborate briefly as appropriate in the spaces following each item.

	Yes	No	S/R	Date	Comment/Details		Yes	No	S/R	Date	Comment/Details
Head Injury	___	___	___	___	_____	Stomach Trouble	___	___	___	___	_____
Back Injury	___	___	___	___	_____	Psychiatric Trtmt	___	___	___	___	_____
Diabetes	___	___	___	___	_____	Lung Disease	___	___	___	___	_____
Heart Disease	___	___	___	___	_____	Seizures	___	___	___	___	_____
Hepatitis	___	___	___	___	_____	Chronic Back Pain	___	___	___	___	_____
Asthma	___	___	___	___	_____	Sinus Trouble	___	___	___	___	_____
Tuberculosis	___	___	___	___	_____	Skin Disease	___	___	___	___	_____
Epilepsy	___	___	___	___	_____	Allergic Reaction	___	___	___	___	_____
Fainting Spells	___	___	___	___	_____	Urinary Disease	___	___	___	___	_____
Cancer	___	___	___	___	_____	Hypertension	___	___	___	___	_____
Hernia	___	___	___	___	_____	Bleeding Disorder	___	___	___	___	_____
MRSA	___	___	___	___	_____	H1N1 Swine Flu	___	___	___	___	_____

ARE THERE ANY ABNORMALITIES WITH YOUR: (If yes, please explain fully)

SKIN Yes No _____
 HEART Yes No _____
 LUNGS Yes No _____
 OTHER Yes No _____

IMMUNIZATION HISTORY

Record the date (month and year; estimates acceptable if exact date unknown) of basic immunizations and most recent booster.

Diphtheria/Pertussis/Tetanus(DPT) _____ Chicken Pox (date of disease) _____
 Tetanus/Diphtheria (TD) _____ Tetanus Booster _____
 Measles _____ Rubella (German Measles) _____
 Mumps _____ Polio (oral or injection) _____
 Tuberculin Test (indicate + or -) _____

Have you ever :

Required any psychiatric counseling or hospitalization? (If yes, give dates & diagnosis) _____
 Had operations or serious illnesses? (If yes, dates/details) _____

 Had a disability or chronic illness? (If yes, dates/details) _____
 Any special needs as result of health concern or disability? (If yes, dates/details) _____

Any specific activities to be encouraged or limited by physician's advice: _____
Any exposure to contagious disease in the last 4 weeks (If yes, dates/details): _____
Current medications: _____
Name of family physician: _____ Phone(_____) _____
Are you covered by medical insurance? __Yes __No
List Insurance Carrier and policy #: _____

This health history is correct as far as I know, and the person listed above has permission to engage in all camp activities except as noted. I hereby give permission to the camp to provide ongoing health care, to select medical personnel, and order x-rays, routine tests, or provide other medical treatment for the person listed above.

EMERGENCY TREATMENT AUTHORIZATION: In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Hebron, Inc. staff to hospitalize, secure proper treatment for, and order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied and/or faxed for use out of camp.

Signature of staff member or their parent/guardian if under age 18 _____ Date: _____

Witness (state relationship to staff member) _____ Date: _____

HEALTH EXAMINATION BY LICENSED PHYSICIAN OR MEDICAL PROFESSIONAL

I have examined the above camp staff member on: _____ (date of exam). It is my opinion that the applicant's physical and emotional conditions ^(check one) __ **do allow** __ **do not allow** them full participation in an active, physically demanding summer camp program. This staff member is under the care of a physician for the following condition(s): _____

I understand that Camp Hebron will place this person in close contact with children and other campers. I ^(check one) __ **am not** __ **am** aware of a condition or illness which would present a danger to others through this close contact. If aware of a condition, please explain: _____

Current treatment (include medications): _____
Explanation of any reported loss of consciousness, convulsion, or concussion: _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP

List any treatment to be continued at camp: _____

List any medications to be administered at camp (specific dosages): _____

List any known allergies (food, drug, plant, insect, etc): _____

List any medically prescribed meal plan/dietary restrictions: _____

List any additional health information: _____

Licensed physician's/medical professional's signature: _____

Printed Name: _____

Address _____

Phone(_____) _____ Date of form completion _____