

CAMP SCATICO

SUMMER 2010

STAFF HEALTH HISTORY AND EXAMINATION FORM

Name _____ **Gender** Female Male

Birth date _____ *Last* *First* Age at Camp _____ Social Security # _____
Month / Day / Year

Home Address _____
Street Address *City* *State* *Zip* *Country*

Phone Numbers: _____
(List and label all phone numbers in order of preference)

Email: _____

Emergency Contact:

Name: _____ Relationship: _____
(Print Name)

Address: _____
Street Address *City* *State* *Zip* *Country*

Phone Number: _____
(List and label all phone numbers for this contact person)

Insurance Information (attach photocopy of insurance card/s, front and back)

Name of Policy Holder _____ SS# _____ DOB _____

Employer Name & Address of Policy Holder _____

Insurance Co. Name _____ Insured ID# _____ Group # _____

Insurance Co. Address _____ Insurance Co. Phone # _____

Physician Information (Indicate the doctor(s) we should contact if necessary)

Name of Physician _____ Phone _____

Other _____ Phone _____

PERMISSION TO PROVIDE NECESSARY TREATMENT AND TO RELEASE MEDICAL INFORMATION:

I hereby give permission to the camp to provide me with routine health care, administer or dispense prescription and over-the-counter medications and seek medical treatment including ordering x-rays or tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes and to provide or arrange necessary transportation for me. I authorize any physician, nurse or health care provider to communicate with the medical staff and directors of Camp Scatico, or their designees, about my medical condition, treatment, and/or prognosis. I further authorize the camp medical staff to discuss my medical conditions with the directors, or their designees, when the medical staff, in its sole discretion, believes such communication to be in my best interest or in the best interest of the camp community. In the case of an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization. This completed form may be photocopied for trips out of camp.

EMPLOYEE SIGNATURE: _____

STAFF SIGN HERE

A parent or guardian must sign below for staff born after 6/1/92:

Print Name _____ Signature _____ Date _____

PARENT SIGN HERE

Employee Name: _____

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Fill in the following information and have your physician review it *within the past six months. The camp health personnel must be informed of any changes to this form upon arrival at camp.*

Place one check (✓) in the appropriate column that corresponds to each item below. If "yes" provide details and dates:

	Yes	No		Yes	No		Yes	No
High Blood Pressure			Insomnia			Frequent Diarrhea Constipation		
Convulsive Disorder			Skin Rashes			Shortness of Breath		
Diabetes			Seasonal Allergies			Recent Weight Loss/Gain		
Emotional Problems			Frequent UTIs			Smoke Cigarettes		
Headaches			Anemia			Fifth's Disease / /		
Asthma			Heart Disease			Chicken Pox / /		
Bleeding Problems			Eating Disorder			Measles / /		
Depression/Anxiety			Hepatitis A,B,C			Mumps / /		
Night Sweats			Lice/Scabies			Rubella / /		

If answered "yes", please provide specific details _____

Any other history of medical conditions or surgical procedures: _____

ALLERGIES

List Medication allergies

Are you receiving regular allergy shots? Yes No

Describe reaction and management of the reaction.

List Food allergies

Other allergies (list: include insect stings, hay fever, asthma, animal dander, etc.)

New York State Public Health Law, Chapter 2164, requires that everyone complete and submit the following information.

CHECK (✓) ONE (1) BOX ONLY AND SIGN BELOW. I have:

- had the meningococcal meningitis immunization (Menomune) within the past 10 years.
Date Received: _____
- had the meningococcal meningitis immunization (Menactra TM).
Date Received: _____
- read, or have explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I will **not** obtain immunization against meningococcal meningitis disease.

EMPLOYEE SIGNATURE _____ DATE _____

STAFF SIGN HERE

A parent or guardian must sign below for staff born after 6/1/92:

Print Name _____ Signature _____ Date _____

PARENT SIGN HERE

Employee Name: _____

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Please give DATES for ALL DOSES for the following immunizations:

DTP #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ #5 ___/___/___
Month Day Year Month Day Year Month Day Year Month Day Year Month Day Year

TD (Tetanus/Diphtheria) #1 ___/___/___ Haemophilus (HIB) #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
(within 10 years) Month Day Year Month Day Year Month Day Year Month Day Year

Polio #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
Month Day Year Month Day Year Month Day Year Month Day Year

Varicella (chicken pox) #1 ___/___/___ #2 ___/___/___
Month Day Year Month Day Year

MMR #1 ___/___/___ #2 ___/___/___ or Measles #1 ___/___/___ #2 ___/___/___
Month Day Year Month Day Year Month Day Year Month Day Year

or Mumps #1 ___/___/___
Month Day Year

or Rubella #1 ___/___/___
Month Day Year

Hepatitis B #1 ___/___/___ #2 ___/___/___ #3 ___/___/___
Month Day Year Month Day Year Month Day Year

H1N1 (Intranasal or IM) #1 ___/___/___
(circle one) Month Day Year

I am under the care of a physician for the following condition/s:

Current treatment at the time of this report includes: _____

Treatment to be continued at camp: _____

Description of any limitation or restriction on camp activities, including dietary restrictions: _____

Use this space to provide any additional information about your behavior and physical, emotional, or mental health about which the camp should be aware: _____

This health history is correct and complete as far as I know, and I have permission to engage in all camp activities **except as noted**. I will advise the camp of any changes to this form upon arrival at camp.

EMPLOYEE SIGNATURE _____ DATE _____

A parent or guardian must sign below for staff born after 6/1/92:

Print Name _____ Signature _____ Date _____

PARENT SIGN HERE

Employee Name: _____

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TO BE COMPLETED BY PHYSICIAN WITHIN THE PAST SIX MONTHS

Date of Exam _____ Ht. _____ Wt. _____ Pulse _____ BP _____ T _____ Resp _____

Head _____ Heart _____

Eyes _____ Breasts _____

Vision _____ Corrected _____ Abdomen _____

Ears _____ GYN _____

Nose _____ Lymphatics _____

Mouth & Throat _____ Extremities _____

Neck _____ Neurological _____

Chest _____ Skin _____

Date of last TST (Mantoux) _____ Result _____ If positive, date of chest-x-ray _____ Result _____

CBC (*within last 6 months*) Date: _____ Result: _____

Urinalysis (*within last 6 months*) Date: _____ Result: _____

PRESCRIPTIONS (The camp is requiring that USA employees under 18 years of age subscribe to CampMeds.)

Please list all medications—*prescriptions and over-the-counter*—to be taken during camp, *even those only taken on an “as needed” basis*. Nurses cannot administer medications (prescription or over-the-counter) unless the *physician signs below*.

Name of Medication	Frequency and Dosage	Reason for Taking

RESTRICTIONS ON OVER-THE-COUNTER MEDICATIONS

Camp physicians may prescribe OTC medications such as Tylenol, Claritin and cortisone cream. List any restrictions on non-prescription medications.

Indicate **ALL** medications taken during the year that will **NOT** be taken during the camp season:

Licensed Medical Personnel Authorization: I have reviewed this form in its entirety. The health history and physical exam is complete and the participant has permission to engage in all camp activities **except as noted above**.

Print Name _____ Signature _____ Date _____

PHYSICIAN SIGN HERE

License # _____ Address _____ Phone _____

Reviewed and Screened by Camp Scatico Health Care Provider: _____
Name Signature Date