

CAMP OUR TIME HEALTH SERVICES – 2010 HEALTH HISTORY EXAMINATION FORM - STAFF

330 West 42nd St., 12th Fl., New York, NY 10036

The information on this form is used to identify appropriate health care, not to screen out staff. These forms are confidential and kept separate from other personnel records. This **original form** is due by **July 30th**. Pages 1 & 2 must be completed by staff person or parent/guardian if under the age of 18.

NO health care, including regular medication, can be given without this form.

NAME _____ D.O.B. ___/___/___ AGE _____

HOME ADDRESS _____ PHONE _____

PARENTS /EMERGENCY CONTACT _____ PHONE _____

ADDRESS _____

_____ Email address _____

FATHER WORK _____
FATHER CELL _____

MOTHER WORK _____
MOTHER CELL _____

WILL YOUR EMERGENCY CONTACT BE AT THE ABOVE ADDRESS FOR THE ENTIRE SUMMER? r YES r NO
If NO please include your travel itinerary. If not available in an emergency notify:

NAME _____ RELATIONSHIP _____

ADDRESS _____ PHONE _____

Health History Diseases Allergies (Epi pen required Y/N?)

_____ Frequent ear infections	_____ Chicken Pox	_____ Penicillin
_____ Heart defects/diseases	_____ Measles	_____ Other drugs _____
_____ Convulsions/Epilepsy	_____ German Measles	_____ Bee Stings
_____ Bleeding/Clotting Disorders	_____ Mumps	_____ Asthma
_____ Hypertension	_____ Fifths Disease	_____ Food Allergies please list
_____ Mononucleosis		_____

THIS INFORMATION IS REQUIRED FOR YOU TO BE SEEN IN A HOSPITAL OR DOCTOR'S OFFICE. CAMP DOES NOT SUBMIT CLAIMS ON BEHALF OF STAFF TO INSURANCE COMPANIES.

Medical Insurance or Health Care Coverage provided by _____

Personal Identification # _____

Group coverage under the name of _____

Insurance Company Billing address _____

Company telephone number _____

THE CAMP SHALL NOT BE LIABLE FOR ANY EXCESS OR AMOUNTS NOT COVERED BY THE HEALTH CARE PROVIDER ABOVE

Important - This Box Must be Completed for Attendance

To the best of my knowledge, this health history is correct and complete, and the person herein described has permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order: x-rays, routine tests, treatment, and necessary transportation for myself. In the event that I can't give my authorization in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer any/all treatments and/or procedures she/he deems necessary, including hospitalization. Furthermore, I authorize the release of any/all of my medical records as requested by the attending camp staff member. **Authorization of Health Insurance:** I hereby give my permission to the camp director to submit my Health Insurance coverage as an authorized third party. This form may be photocopied for trips out of camp.

Signature _____ Date _____

REQUIRED

CAMP OUR TIME HEALTH CARE SERVICES

This side to be filled in by staff member

NAME OF FAMILY PHYSICIAN _____ PHONE _____

NAME OF DENTIST/ORTHODONTIST _____ PHONE _____

If staff member wears eyeglasses, contact lenses

NAME OF EYE PHYSICIAN _____ PHONE _____

PRESCRIPTION: L _____ R _____ Is staff member bringing spare pair? _____

Please complete the following questions with as much information as possible. Use additional sheet if necessary. If you will be coming to camp with any medication please contact the Camp Our Time office and request a medication record. No medication can or will be given without this record being completed.

1. **Any** surgical operations?

2. **Any** hospitalizations?

3. **Any** serious injuries, including fractures/dislocations? _____
4. **Any** chronic or recurring illness? _____
5. **Any** loss of consciousness, convulsions or concussions? _____
6. **Any** camp activities to be restricted? _____
7. **Any** medication **not** to be given? If so, what? (give reason). _____
8. Do you exhibit **any** particular characteristics when unwell? _____
9. Have you been taking **any** prescription medication during the last 12 months? If so, please explain.

10. Medication(s) to be given at camp (you must complete additional medication form)

11. Details of **any** specific health care you may require while at camp. _____

12. Any prescription preferences should you require **any** medication while at camp, (i.e. choice of antibiotic, liquid, chewable, tablet, generic equivalents).

13. Have you ever had an allergic reaction to **any** medication, insects or foods (including over-the-counter, or topical)? If so give details.

14. Refill procedure. (If you are bringing any medication to camp, please indicate whether you will have refills sent , or if you would like us to refill here at camp).

15. Has staff member menstruated? _____

16. Have you ever in the past or present being treated or under the supervision of any doctors, therapists, social workers, psychologist etc? If yes, please explain

Additional comments, including any concerns you would like our staff to pay particular attention to, should be included on an additional sheet. **FULL MEDICAL DISCLOSURE IS MANDATORY**

This side to be filled in by a licensed physician - please do not separate. The camp relies upon the truth and accuracy of this information, not to discriminate, but to determine the appropriateness of this placement, and the camp's ability to accommodate the staff member as part of its decision to accept or reject any staff member.

STAFF NAME

IMMUNIZATION HISTORY

Please record the date (month and year) of basic immunizations and most recent booster doses:

VACCINES	YR OF BASIC IMMUNIZATION	YEAR OF LAST BOOSTER
Diphtheria /Pertussis/Tetanus, (DPT)	1 2 3	1 2
Tetanus/Diphtheria, (DT)		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles, (hard measles, red measles, rubeola)		
Mumps		
Rubella, (German Measles, 3 day Measles)		
Other		
Tuberculin test given _____ (most recent)		
Hemophilus Influenza b (HIB)		
Hepatitis B		
Hepatitis A		
Bacterial Meningitis (Menomune)		
Chickenpox (varicella)		

Height _____ Weight (lbs) _____ Blood Pressure _____ Blood Type, (if known) _____

HEALTH CARE RECOMMENDATIONS BY LICENSED PHYSICIAN

I have personally examined the above named staff applicant on _____ (Examination date). In my opinion, full participation in camp activities should be permitted except for the following:

The applicant has been or is presently under the care of a physician, therapist, social worker etc, for the following condition(s).

Current treatment of above (include medications)_____

Is treatment to be continued at camp? If yes, give details. If no, please explain and indicate possible side effects to watch for.

Any allergies? (drugs, foods, plants, insects, etc.) Epi pen required?_____

Any medically prescribed meal plan or dietary restrictions?_____

Additional health information from physicians, therapists and social workers._____

Name of Physician _____ Signature _____ Date _____

Address _____ Phone _____

CAMP OUR TIME IN-CAMP HEALTH SCREENING RECORD

This side is for camp use by Health Centre staff only. All Health Centre visits will be entered into a daily log.
STAFF NAME _____

1. Observable evidence of illness, injury, disability or communicable disease.

	ARRIVAL AT CAMP	COMMENTS	DEPARTURE	COMMENTS
TEMPERATURE				
HEIGHT				
WEIGHT				
HAIR				
SKIN, (INC FEET)				
EYES				
EARS				
NOSE				
THROAT				
TEETH				
POSTURE				
	SIGNED		SIGNED	
	DATE		DATE	

2. Any changes to the Health History form since it was completed? r YES r NO

If yes, give details. _____

3. Any known exposure to communicable disease within last 2 weeks? If so, what? _____

4. Record of medication brought to camp and instructions _____

5. Any follow up recommended by person conducting health screening? _____

6. Additional comments/observations: _____