

**HEALTH HISTORY AND EXAMINATION FORM FOR STAFF**

Please print

Name \_\_\_\_\_ Birthday \_\_\_\_\_  
Last First Initial Month/Day/Year

Male  Female Parent/Guardian/Spouse \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City, State, Zip

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City, State, Zip

**Emergency Contact** \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City, State, Zip

Business Address \_\_\_\_\_ Phone \_\_\_\_\_  
Street City, State, Zip

**Second Emergency Contact** \_\_\_\_\_

Name \_\_\_\_\_ Evening phone \_\_\_\_\_ Day phone \_\_\_\_\_

Address \_\_\_\_\_  
Street City, State, Zip

Dentist/orthodontist \_\_\_\_\_ Phone \_\_\_\_\_

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Do you carry medical/hospital insurance?  Yes  No. If so, Name of Carrier \_\_\_\_\_

Policy/Group # \_\_\_\_\_ Name of insured \_\_\_\_\_ Relationship \_\_\_\_\_

**Health History**

The intent of the following information is to provide our health care personnel the background for appropriate care. Keep a copy of the completed form for your records. If you have changes, give them to the nurse upon arrival at camp.

- | Yes                      | No                       | Have/Do you:   | Yes                      | No                       |   |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Had any recent injury, illness or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Ever had high blood pressure?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Have a chronic or recurring illness/condition?        | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever been diagnosed with a heart murmur?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Ever been hospitalized?                               | <input type="checkbox"/> | <input type="checkbox"/> | 16. Ever had back problems?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Ever had surgery?                                     | <input type="checkbox"/> | <input type="checkbox"/> | 17. Ever had problems with joints (e.g., knees, ankles)?                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have frequent headaches?                              | <input type="checkbox"/> | <input type="checkbox"/> | 18. Have an orthodontic appliance being brought to camp?                    |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Ever had a head injury?                               | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have any skin problems (e.g., itching, rash)?                           |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Ever been knocked unconscious?                        | <input type="checkbox"/> | <input type="checkbox"/> | 20. Have diabetes?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Wear glasses, contacts or protective eye wear?        | <input type="checkbox"/> | <input type="checkbox"/> | 21. Have asthma?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Ever had frequent ear infections?                     | <input type="checkbox"/> | <input type="checkbox"/> | 22. Had mononucleosis in the past 12 months?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Ever passed out during or after exercise?            | <input type="checkbox"/> | <input type="checkbox"/> | 23. Have bleeding/clotting disorder?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Ever been dizzy during or after exercise?            | <input type="checkbox"/> | <input type="checkbox"/> | 24. Have an eating disorder?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Ever had seizures?                                   | <input type="checkbox"/> | <input type="checkbox"/> | 25. Ever had emotional difficulties for which professional help was sought? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Ever had chest pain during or after exercise?        |                          |                          |   |

Please explain any "yes" answers, noting the number of the questions. Use extra sheet if necessary.

\_\_\_\_\_  
\_\_\_\_\_

Which of the following have you had?

- Chicken Pox
- Measles
- German Measles
- Mumps
- Hepatitis
- Varicella Zoster

TB Mantoux test: most recent date \_\_\_\_\_  
Result:  Positive  Negative

Give date of last immunization for:

- Tetanus Date: \_\_\_\_\_
- DPT Date: \_\_\_\_\_
- TD (tetanus/diphtheria) Date \_\_\_\_\_
- Measles (hard or red measles or rubeola) Date \_\_\_\_\_
- Rubella Date \_\_\_\_\_
- Haemophilus influenza B Date \_\_\_\_\_
- Polio Date \_\_\_\_\_
- Hepatitis B Date \_\_\_\_\_
- Varicella (chicken pox) Date \_\_\_\_\_ BCG Date \_\_\_\_\_

List all known allergies (Food, medication, insect stings, hay fever, asthma, animal dander, etc.). Describe reaction and management of reaction. Use another sheet if necessary. \_\_\_\_\_

Dietary restrictions \_\_\_\_\_

Activity restrictions \_\_\_\_\_

Please list ALL medications, (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep 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. \_\_\_\_\_

**Important -- This Must be Completed for Attendance\***

This health history is correct so far as I know, 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; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for this staff member. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person as named above. I also agree to be responsible for any expenses which may be incurred in providing emergency medical or surgical treatment to this person. The completed forms may be photocopied for trips out of camp.

**X Signature of applicant** or minor applicants guardian \_\_\_\_\_ Date \_\_\_\_\_

I also understand and agree to abide with the restrictions placed on my camp activities:

**X Signature of minor staff** \_\_\_\_\_ Date \_\_\_\_\_

**Health Care Recommendations by Licensed Medical Professional**

I have examined the above camp participant within two years prior to camp attendance. Date examined \_\_\_\_\_

In my opinion, this person  is  is not able to participate in an active camp program.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

The applicant is under the care of physician for the following conditions \_\_\_\_\_

Current treatment at the time of this report includes \_\_\_\_\_

Recommendations and Restrictions While at Camp \_\_\_\_\_

Treatment to be continued at camp \_\_\_\_\_

Medications to be administered at camp (name, dosage, frequency) \_\_\_\_\_

Medically prescribed meal plan or dietary restrictions \_\_\_\_\_

Known allergies \_\_\_\_\_

Description of any limitation or restriction on camp activities \_\_\_\_\_

Additional Health Information \_\_\_\_\_

**Signature of Licensed Medical Professional** \_\_\_\_\_

Name printed \_\_\_\_\_ Title \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Phone \_\_\_\_\_ Date \_\_\_\_\_