

# CAMP SCATICO

SUMMER 2009

## **STAFF** HEALTH HISTORY AND EXAMINATION FORM

Name \_\_\_\_\_ **Gender**  Female  Male

Birth date \_\_\_\_\_ *Last* *First*  
*Month / Day / Year* Age at Camp \_\_\_\_\_

Home Address \_\_\_\_\_  
*Street Address* *City* *State* *Zip* *Country*

Phone Numbers: \_\_\_\_\_  
*(List and label all phone numbers in order of preference)*

### **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 6/1/91:**

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

**PARENT SIGN HERE**

Employee Name: \_\_\_\_\_

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 6/1/91:

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

PARENT SIGN HERE

Employee Name: \_\_\_\_\_

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

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 \_\_\_\_\_

STAFF SIGN HERE

A parent or guardian must sign below for staff born after 6/1/91:

Print Name \_\_\_\_\_ Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

PARENT SIGN HERE

Employee Name: \_\_\_\_\_

SUMMER 2009

**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 &amp; Throat \_\_\_\_\_ Extremities \_\_\_\_\_

Neck \_\_\_\_\_ Neurological \_\_\_\_\_

Chest \_\_\_\_\_ Skin \_\_\_\_\_

Date of last TB Mantoux Test \_\_\_\_\_ 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

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:

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**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