SUMMER 2011

HEALTH HISTORY AND EXAMINATION FORM
FOR STAFF AT LEAST 18 YEARS OF AGE

Name ____ **Gender** ☐ Female ☐ Male

Last *First*

Birth date ______________ Age on 6/1/11 ________ Social Security # ______________________

Month / Day / Year

For non-US staff only DS 2019 # ________________________ 194 # ________________________

Passport # ________________________ Country of Issue ________________

Home Address ____

Street Address *City* *State* *Zip* *Country*

Phone Numbers and Emails ____

list and label all phone numbers and emails in order of preference

____

Emergency Contact:

Name**:** ________________________ Relationship: ________________________

please print

Address: ____

Street Address *City* *State* *Zip* *Country*

Phone Numbers ____

list and label all phone numbers in order of preference

Insurance Information: attach a copy of front & back of all insurance cards and FSA or credit card

Policy Holder ________________________ SS# ________________ DOB __________

Policy Holder's Employer ____

Insurance Company ________________________________ Phone ________________

Insured ID# ________________________ Group# ________________________

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

Primary 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 diagnostic 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 and transmitted electronically when needed. I also agree to abide by the restrictions placed on my camp activities.

EMPLOYEE SIGNATURE: ____

STAFF SIGN HERE

Employee Name: ____ **SUMMER 2011**

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

Employee Name: ____ **SUMMER 2011**

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

TDaP(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

Influenza **#1**____/____/____
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

Employee Name: ____ **SUMMER 2011**

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