Staff Medical Form

Summer 2014

The information on this form is not part of the staff acceptance process but is gathered to assist us in identifying appropriate care. Health history must be filled out by parents/guardians of minors or by staff themselves (if 18 or over).

Mail this form to the address below by 6/1/14

MOUNT TOM DAY CAMP
48 Mount Tom Road
New Rochelle, NY 10805

Gender: ☐ Male ☐ Female

Name_____ Birth date_____ Age at camp_____
Last First Middle

Home address_____
Street address City State Zip

Custodial parent/guardian_____ Cell Phone_____

Home address_____ Home Phone_____
(if different from above) Street address City State Zip

Business address_____ Bus Phone_____
Street address City State Zip

Second parent / guardian / emergency contact_____ Cell Phone_____
(please circle one)

Address_____ Home Phone_____
Street address City State Zip

Business address_____ Bus Phone_____
Street address City State Zip

If above not available in an emergency, notify:

Name_____ Cell Phone_____

Relationship_____ Day Phone_____

Address_____
Street address City State Zip

Insurance Information

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name_____ Group #_____ Tele #_____

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication allergies (list)

_____ _____
_____ _____
_____ _____

Food allergies (list)

_____ _____
_____ _____
_____ _____

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

_____ _____
_____ _____
_____ _____

Use this space to provide any additional information about the participant's behavior, physical, emotional, or mental health about which the camp should be aware. Please be assured that all information provided on this form will be kept confidential.

_____

_____

_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely.

☐ This person takes NO medications on a routine basis.

☐ This person takes medications as follows:

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #2_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #3_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Attach additional pages for more medications.

Identify any medications taken during the school year that participant does/may not take during the summer:_____

_____

MEDICATIONS ADMINISTERED DURING CAMP

• Must be accompanied by a doctor's written order • Keep in original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, dosage, and frequency of administration • Please provide sufficient medications for entire camp session • All medications will be administered/stored by camp nurse

RESTRICTIONS

The following restrictions apply to this individual.

Dietary

☐ Does not drink milk ☐ Does not eat red meat ☐ Does not eat fish
☐ Does not eat ice cream ☐ Does not eat poultry ☐ Does not eat eggs
☐ Does not eat other dairy products
☐ Other (describe)_____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

_____

_____

General Questions (Explain "yes" answers below)

Has/does the participant:	Yes	No
1. Had a recent injury, illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐
3. Ever been hospitalized?	☐	☐
4. Ever had surgery?	☐	☐
5. Have frequent headaches?	☐	☐
6. Ever had a head injury?	☐	☐
7. Ever been knocked unconscious?	☐	☐
8. Wear glasses, contacts, or protective eyewear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Ever passed out during or after exercise?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐
12. Ever had seizures?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐
14. Ever had high blood pressure?	☐	☐
15. Been diagnosed with a heart murmur?	☐	☐
16. Ever had back problems?	☐	☐
17. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
18. Have an orthodontic appliance being brought to camp?	☐	☐
19. Have any skin problems (e.g. itching, rash, acne, eczema)?	☐	☐
20. Have diabetes?	☐	☐
21. Have asthma?	☐	☐
22. Had mononucleosis in the past 12 months?	☐	☐
23. Had problems with diarrhea/ constipation?	☐	☐
24. If female, have an abnormal menstrual history?	☐	☐
25. Ever had an eating disorder?	☐	☐
26. Ever had emotional difficulties for which professional help was sought?	☐	☐

Please explain any "yes" answers, noting the number of the questions.

_____

_____

_____

_____

Date of last medical examination: _____

Which of the following
has the participant had?

□ Measles
□ Chicken pox
□ German measles
□ Mumps
□ Hepatitis A
□ Hepatitis B
□ Hepatitis C

TB Mantoux Test
Date of last test_____
Result: □ Positive □ Negative
Tetanus
Date of last Immunization_____

New York State Public Health Laws require Staff members
to have had the following immunizations:

1. Diptheria – 3 or more doses of diptheria toxoid
2. Polio – 3 or more doses of trivalent oral poliovirus vaccine (TOPV)
   or 4 or more doses of inactivated poliomyelitis vaccine (IPV)
3. Measles – 1 dose of live measles vaccine administered after age of
   12 months
4. Mumps – 1 dose of live mumps vaccine administered after age of
   12 months
5. German Measles – 1 dose of live rubella virus vaccine administered
   after age 12 months or setiolgical evidence
   (blood test) of rubella antibodies

I HEREBY CERTIFY THAT I HAVE RECEIVED THE INOCULATIONS LISTED ABOVE

Signature_____

Name of family physician_____ Phone_____

Address_____

Name of family dentist/orthodontist_____ Phone_____

Address_____

Parent/Guardian/Adult Staff Authorization

This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer over the counter and/or prescribed medications with doctor's orders only, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above with the understanding that the family will be notified as soon as possible. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian or adult staffer_____

Printed name_____ Date_____

I also understand and agree to abide by any restrictions placed on my child's/my own participation in camp activities.

Signature of parent/guardian or staffer_____ Date_____