## Staff Medical Form

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).

**Summer 2011**

Mail this form to the address below by 6/1/11
**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___________________________