

**Staff Medical Form**

**Summer 2010**

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 6/1/10  
**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 ice cream
- Does not eat other dairy products
- Other (describe) \_\_\_\_\_
- Does not eat red meat
- Does not eat poultry
- Does not eat fish
- Does not eat eggs

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

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 seriological 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 \_\_\_\_\_