



HEALTH HISTORY AND EXAMINATION FORM FOR SUMMER WORK TRAVEL STAFF

The information on this form is not part of the staff acceptance process, but is gathered to assist us in identifying appropriate care. Please understand, the more information we have the better able we are to ensure a safe and healthy summer. This form, except for the "Health Recommendations of Licensed Medical Personnel", is to be filled in by parents/guardians of minors or by staff over 19 years old.

Name Last _____ First _____ Middle Initial _____

Home Address: # & Street _____ City _____

State _____ Zip/Postal Code _____ Country _____

Participant Social Security Number (US staff) _____ Male _____ Female _____ Birth Date _____ Age _____

Custodial Parent/Guardian _____ Home Phone _____ Work Phone _____ Cell/Mobile Phone _____ Home Address Street _____ City _____ State _____ Zip/Postal Code _____ Country _____	Custodial Parent/Guardian _____ Home Phone _____ Work Phone _____ Cell/Mobile Phone _____ Home Address Street _____ City _____ State _____ Zip/Postal Code _____ Country _____
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EMERGENCY CONTACT INFORMATION If Parent(s)/Guardian(s) are not available in an emergency, please contact:

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Cell/Mobile Phone _____

INSURANCE INFORMATION (If travel insurance plan, please indicate and give details)

Is the Participant covered by family medical/hospital insurance? Yes _____ No _____

If so, indicate carrier/plan name _____ Group # _____ Policy # _____

Carrier Address _____

Claims/Phone Authorization # _____ Co-Pay Amount _____

Name of Insured _____ Relationship to Participant _____

PRESCRIPTION/MEDICATION PLAN INFORMATION (if applicable)

Name of Insured _____ Insured SS# _____ Relationship _____

Company Name _____ Group # _____ Policy # _____

Prescription Information # _____ Co-Pay Amount: Generic _____ Brand _____

A COPY OF FRONT AND BACK OF YOUR INSURANCE AND PRESCRIPTION ID CARD/S MUST BE ATTACHED TO THIS FORM!

IMPORTANT- THIS BOX MUST BE COMPLETE FOR ATTENDANCE

PARENT/GUARDIAN/STAFF OVER 19 AUTHORIZATIONS: This health history is correct and complete as far as I know. The person herein described has permission to engage in all work related activities except as noted. I hereby give permission to the employer to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the employer to arrange necessary related transportation for me. In the event that I cannot be reached in an emergency, I hereby give permission to the physician/health care provider selected by the employer to secure and administer treatment, including hospitalization, for the person named above.

Signature _____ Printed Name _____ Date _____

I also understand and agree to abide by any restrictions placed on my participation work related activities.

Signature _____ Date _____

HEALTH HISTORY

The following information must be filled in by the parent/guardian, or adult camper or staff member (over 19). The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

It is our experience that more and more people are availing themselves of the service of psychiatrists, psychologists, social workers, and counselors to deal with a variety of complex issues and emotional difficulties. The CCS policy is not to disqualify you with problems provided they can function in a camp environment. It is therefore necessary that a candid description of past, present, and potential difficulties be honestly described for the confidential use of the professional staff, to enable us to intelligently and sensitively work with your child should any problems arise.

ALLERGIES *Please describe reaction and management of the reaction.*
MEDICATION ALLERGIES

- ___ Penicillin _____
- ___ Amoxicillin _____
- ___ Septra _____
- ___ Aspirin _____
- ___ Erythromycin _____
- ___ Sulpha _____
- ___ Other _____

FOOD ALLERGIES

- ___ Nuts _____
- ___ Shellfish _____
- ___ Eggs _____
- ___ Other _____

OTHER ALLERGIES

- ___ Hay Fever _____
- ___ Ivy Poisoning _____
- ___ Bee Stings _____
- ___ Insect Stings _____
- ___ Other _____

MEDICATIONS BEING TAKEN

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **Keep it in the original packaging** bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

___ 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 or information about side effects. Identify any medications taken during the school year that participant does/may take during the summer:

I give permission to the Camp Health Personnel to dispense any medications as needed. ___ Yes _____ No

RESTRICTIONS

Dietary

- ___ Does not eat red meat ___ Does not eat fish ___ Does not eat eggs ___ Does not eat poultry ___ Does not eat dairy
- ___ 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

	YES	NO		YES	NO
Has/does the participant:					
1. Had any recent injury, illness, or infectious disease?	___	___	17. Ever had epilepsy?	___	___
2. Have a chronic or recurring illness/condition?	___	___	18. Ever had treatment for drug/alcohol abuse?	___	___
3. Ever been hospitalized?	___	___	19. Have a history of smoking? If so, how many?	___	___
4. Ever had surgery?	___	___	20. Ever had problems with joints (e.g. knees, ankles)?	___	___
5. Have frequent headaches?	___	___	21. Have an orthodontic appliance brought to camp?	___	___
6. Ever had a head injury?	___	___	22. Have any skin problems (e.g. itching, rash)?	___	___
7. Ever been knocked unconscious?	___	___	23. Have diabetes? (Date of onset)	___	___
8. Wear glasses, contacts, or protective eyewear?	___	___	24. Have asthma? (Date of onset)	___	___
9. Ever had frequent ear infections?	___	___	25. Had mononucleosis in the past 12 months?	___	___
10. Ever passed out during or after exercise?	___	___	26. Had problems with sleepwalking?	___	___
11. Ever been dizzy during or after exercise?	___	___	27. Have problems with diarrhea/constipation?	___	___
12. Ever had seizures/convulsions?	___	___	28. Have a history of bed-wetting?	___	___
13. Ever had chest pain during or after exercise?	___	___	29. Ever had an eating disorder?	___	___
14. Ever been diagnosed with a heart murmur?	___	___	30. Ever had emotional difficulties for which professional help was sought?	___	___
15. Ever been diagnosed with high blood pressure?	___	___	31. Ever been diagnosed with ADD/ADHD?	___	___
16. Ever had back problems?	___	___			

Please explain any “yes” answers, noting the number of the question being addressed.

HEALTH HISTORY

Which of the following has the participant had?

- ___ Measles
- ___ Chicken Pox
- ___ German Measles
- ___ Mumps
- ___ Hepatitis A
- ___ Hepatitis B
- ___ Hepatitis C
- ___ Rheumatic Fever

IMMUNIZATION HISTORY – WITH DATES

This is a record of **DATES** of basic immunization and booster doses

- ___ DPT _____
- ___ Polio OPV (Sabin) _____
- ___ MMR _____
- ___ or measles _____
- ___ or Mumps _____
- ___ or Rubella _____
- ___ Smallpox _____
- ___ Tetanus Booster _____
- ___ Hepatitis B _____
- ___ TB Mantoux Test- Date of last test _____ Result: _____
- ___ Other _____

IMPORTANT – THIS BOX MUST BE COMPLETE FOR ATTENDANCE

Parent/Guardian/Staff Member over 19 Authorizations

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

Signature _____ Printed _____
 Date _____

Disclosure of Medical Information

I understand that the Camp is not defined as an entity subject to HIPAA (Health Information Privacy)**** and therefore is not covered by HIPAA regulations concerning the patient medical records. I also understand and agree that situations may necessitate that medical information be shared with the administrative staff, the camp doctors and nurses and the faculty. I give permission to any Health Care Provider, such as a hospital or physician to share my medical information with the Camp doctors and nurses and other Camp medical staff, for treatment purposes.

Signature _____ Printed _____
 Date _____

*** For more information visit <http://www.hhs.gov/ocr/hipaa/>

MEDICAL EXAMINATION – To be completed and signed by a licensed physician

This examination should be performed within twelve months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: S= Satisfactory X= Not Satisfactory (explain) O= Not Examined * if applicable
Hgt _____ Wt _____ Hgb Test _____ Urinalysis _____ Eyes _____ Glasses/Contacts _____
Ears _____ Nose _____ Throat _____ Teeth _____ Heart _____ Lung _____
Extremities _____ Posture (spine) _____ Skin _____ Hernia _____

For FEMALE – Has this person menstruated? _____ If not, has she been told about it? _____
If so, is her menstrual history normal? _____

Known allergies _____

General Appraisal _____

Special Considerations _____

RECOMMENDATIONS AND RESTRICTIONS

Special medicine or injections – please specify _____

Medications discontinued prior to summer. If so, why? _____

Swimming, diving, and/or strenuous activity? _____ Exposure to the sun and heat? _____

Other _____

Is there any congenital malformation now existing that may require special treatment or consideration? _____

If yes, please explain? _____

Is there any history of emotional disturbance in the applicant? _____

Has she/he shown any:

Difficulties in the relationship with parents, authority figures, persons of his/her own age? _____

Behavioral disorders? _____

Emotional symptoms such as mood swings, depression, sleep disorders, unusual degree of anxiety, fear or guilt? _____

Please explain _____

Has the applicant been to a psychiatrist within the last 4 years? _____

Has this applicant been involved in psychological therapy? _____

To your knowledge, is there any history of drug/alcohol related problems? _____

If yes, please explain _____

Does this person smoke cigarettes? _____ If yes, how many a day? _____

I have examined this individual and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in camp activities except as noted above. I have been this applicant's physician for _____ years.
Examining Physician _____ Printed _____ Date _____
Address _____
Telephone number _____

FOR CCS USE ONLY

Date Received _____ Date Reviewed _____

FOR CAMP USE

Date Received _____ Date Reviewed _____