Brethren Woods

STAFF Health History Form

Staff Name: _____
First Middle Last

Preferred Name: _____

Dates of Camp(s): _____ Year: _____

Birth Date: _____ Age at Camp: _____

DIRECTIONS:

1. **Complete pages 1-3 as accurately as possible. Attach a copy of BOTH SIDES of your insurance card, if appropriate.**
2. **HEALTH FORMS MUST BE RECEIVED IN THE CAMP OFFICE AT LEAST 14 DAYS PRIOR TO ARRIVAL.**
3. **Be sure to bring all medications listed with you to camp in their ORIGINAL CONTAINER with the ORIGINAL LABEL.**

Contact Information

Home Address: _____
Street City State Zip Code

Phone Number(s): Cell _____ Home _____ Work _____

Emergency Contact to be contacted in case of illness or injury:
Name: _____ Relationship to Staff Member: _____
Preferred Phone Number(s): Cell _____ Home _____ Work _____

Additional Contact Information – This information is REQUIRED for minor staff (under 18) and OPTIONAL for adult staff (18+).

Parent/Guardian with legal custody to be contacted in case of illness or injury:
Name: _____ Relationship to Staff Member: _____
Preferred Phone Number(s): Cell _____ Home _____ Work _____
Email Address: _____
Home Address (if different from above): _____
Street City State Zip Code

Second Parent/Guardian to be contacted in case of illness or injury:
Name: _____ Relationship to Staff Member: _____
Preferred Phone Number(s): Cell _____ Home _____ Work _____

Health Care Providers

Name of Primary Doctor/Practice: _____ Phone Number: _____

Name of Dentist(s)/Orthodontist(s): _____ Phone Number: _____

Medical Insurance Information – *Attach a copy of BOTH SIDES of your insurance card, if appropriate.*

- ☐ I am NOT covered by family medical/hospital insurance.
- ☐ I AM covered by family medical/hospital insurance. ***Describe below.***

Insurance Company: _____ Phone Number: _____

Subscriber: _____ Policy Number: _____

Acknowledgement and Authorization for Health Care

This health history is correct and accurately reflects the health status of the staff member to whom it pertains. The person described has permission to participate in all camp activities except as noted. I understand that first aid supplies and equipment, including an AED, are available on-site at camp. I give permission to the camp healthcare provider(s) to provide routine health care, including administering medications. The camp generally does not contact parents/guardians or emergency contacts if staff are seen by the camp healthcare provider for routine problems (e.g., skinned knees, sore throat, headache) that do not require a physician referral. This includes overnight stays in the health center. The decision to consult parents/guardians or emergency contacts in these situations is determined on a case-by-case basis by our healthcare provider. I understand I must attach a letter to this form if I want the camp to follow a practice different from what is described. In case of an emergency, the camp healthcare provider will make every effort to contact parents/guardians or emergency contacts by phone, using the numbers provided on this form, if the staff listed has need for out-of-camp healthcare, but the camp cannot promise that it will be successful in reaching these persons. If these persons cannot be reached in an emergency, I give permission to the physician selected by the camp to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this staff member. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of me or my child for both routine health care and emergency situations. I give permission to the camp to arrange necessary related transportation for me or my child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of me or my child's health record from providers who treat me or my child and these providers may talk with the camp staff about my or my child's health status.

Signature of Staff Member or Custodial Parent/Guardian of Minor Staff: _____

Relationship to Staff: _____ **Date:** _____

General Health History – ***Completing this section is OPTIONAL but ENCOURAGED for all staff, especially minors. Circle YES or NO for each statement. Explain any YES answers in the space below.***

Have/Do you:

1.	Ever been hospitalized?	YES	NO	11.	Had fainting or dizziness?	YES	NO
2.	Ever had surgery?	YES	NO	12.	Passed out/had chest pain during exercise?	YES	NO
3.	Have recurrent/chronic illnesses?	YES	NO	13.	Had mononucleosis ("mono") during the past 12 months?	YES	NO
4.	Had a recent infectious disease?	YES	NO	14.	If female, have problems with periods/menstruation?	YES	NO
5.	Had a recent injury?	YES	NO	15.	Have problems with falling asleep/sleepwalking?	YES	NO
6.	Had asthma/wheezing/shortness of breath?	YES	NO	16.	Ever had back/joint problems?	YES	NO
7.	Have diabetes?	YES	NO	17.	Have a problematic history of bedwetting?	YES	NO
8.	Had seizures?	YES	NO	18.	Have problems with diarrhea/constipation?	YES	NO
9.	Had headaches?	YES	NO	19.	Have any skin problems?	YES	NO
10.	Wear glasses, contacts or protective eyewear?	YES	NO	20.	Traveled outside the country in the past 9 months?	YES	NO

Please explain any YES answers in the space below, noting the question number. For seizures, give date of last seizure and describe seizures (duration, aura, etc.) For travel outside the country, list dates and countries visited. Attach sheets with additional information if needed.

Immunization History

In order to protect the entire camp community, we strive to have the highest possible level of fully immunized campers and staff. The Center for Disease Control, Commonwealth of VA, and American Camp Association recommend that all school age and older campers and staff have at least the following immunizations:

- Mumps, Measles, Rubella (MMR) - 2 doses
- Polio (IPV) - 4 doses
- Hepatitis B (Hep B) - 3 doses
- Varicella/Chicken Pox - 2 doses or evidence of having the disease
- **Diptheria, Tetanus, Pertussis (DTaP, TdaP, DTP, DT) - 4 doses**
  Date of last Tetanus booster: Month_____ Year _____

Please indicate your camper/staff level of immunization below and attach a copy of any available immunization record, including dates, to verify this information. <u>Be sure to record the date of the last Tetanus shot above.</u>

- ☐ YES, I am FULLY immunized as described above. ***Please attach immunization record to verify.***
- ☐ NO, I am NOT fully immunized as described above. I understand this creates risks for me/my child including potential exposure to severe illness and the need to leave camp early in the case of unknown illness to avoid endangering others. ***Please attach any available immunization record.***

Allergies – ***Persons with food allergies should complete a Food Allergy & Special Diet Questionnaire for our Food Service Staff.***

- ☐ No known allergies.
- ☐ Allergies to food, medicine, environment (insect stings, hay fever, etc.), or other. ***Describe in detail below.***

Allergen	Severity and Time Till Reaction	Reaction Experienced	Management Required	Ability of Camper to Manage Allergy & Threats

Diet/Nutrition – ***Persons with intolerances should complete a Food Allergy & Special Diet Questionnaire for our Food Service Staff.***

- ☐ Eats a regular diet.
- ☐ Eats a regular vegetarian diet.
- ☐ Eats a diabetic diet.
- ☐ Lactose intolerant.
- ☐ Gluten intolerant.
- ☐ Other diet. ***Describe in detail below.***

Activity Restrictions

- ☐ I have reviewed the program and activities of the camp and feel I can participate WITHOUT restrictions.
- ☐ I have reviewed the program and activities of the camp and feel I can participate WITH the following restrictions or adaptions. ***Describe in detail below. Attach sheets with additional information if needed.***

Mental, Emotional, and Social Health – ***Completing this section is OPTIONAL but ENCOURAGED for all staff. Circle YES or NO for each statement. Explain any YES answers in the space below.***

Have you:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? YES NO
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? YES NO
3. During the past 12 months, seen a professional to address mental/emotional health concerns? YES NO
4. Had a significant life event that continues to affect your life? YES NO
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, etc.)

Please explain any YES answers in the space below, noting the question number. Attach sheets with additional information if needed.

Heath Center Medications – ***Please cross out any items that you should NOT be given.*** **This information is REQUIRED for minor staff.**

The following non-prescription medications (name brand or generic) MAY be stocked in the camp Health Center and are available for use on an as needed basis to manage illness and injury. You DO NOT need to bring these medications with them to camp unless prescribed and/or needed for regular use.

Acetaminophen (Tylenol) / Ibuprofen (Advil, Motrin)
Phenylephrine decongestant (Sudafed PE, Cold/Sinus)
Antihistamine/allergy medicine
Diphenhydramine antihistamine/allergy medication (Benedryl)
Sore throat spray
Calamine lotion (Caladryl)
Laxatives for constipation (Milk of Magnesia, Ex-Lax, suppositories)
Antacid (Tums)
Zanfel for poison ivy
Epi-Pen (regular, junior)
Pseudoephedrine decongestant (Sudafed)
Guaifenesin cough syrup (Robitussin, Robitussin CF)
Dextromethorphan cough syrup (Robitussin DM)
Generic cough drops
Antibiotic cream
Hydrocortisone cream
Aloe, Aloe vera
Bismuth subsalicylate for diarrhea (Imodium, Pepto-bismol)
Midol
Sunscreen

Staff Medications – ***A "medication" is any substance a person takes to maintain and/or improve their health. This includes prescription and over-the-counter substances, including vitamins and natural/health remedies. Camp health staff will ask about your medications to determine if the use (or non-use) of such medications will impair your ability to perform the essential functions of your position.***

- ☐ I will NOT bring any medications to camp.
- ☐ I am an ADULT staff member (18+) and WILL bring medications to camp to be managed by myself. ***I understand that all medications must be stored in a secure area under lock and away from minors (ex. locked vehicle, staff housing, or health center) except for emergency medications (ex. Epi-Pen, inhaler, insulin, etc.) when in the controlled possession of the person responsible for administering them. Camp health staff may assist you in managing your medications by storing them for you and making them available to you at appropriate times.***
- ☐ I am a MINOR (under 18) or ADULT (18+) staff member and WILL bring the following medications to camp to be managed by camp staff. ***Attach sheets with additional information if needed. Be sure to bring all medications listed with you to camp in their ORIGINAL CONTAINER with the ORIGINAL LABEL showing your name, prescribing physician (if applicable), name of the medication, dosage, frequency, and how the medication is to be given. Medicines will be stored and administered by camp health staff.***

Medication Name	Date Started	Reason for Taking	When it is Given	Amount or Dose Given	How It is Given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other: _____		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other: _____		

Anything Else? – ***Please provide any additional information in the space below that you think important or that may affect your time at camp. Attach sheets with additional information if needed.***

Individual Health Record – *For Camp Staff Use Only*

Health Screening

Date: _____ Time: _____ Initials: _____

Circle YES or NO for each question. Explain any YES answers in the space below.

1. Any signs/symptoms of illness or injury upon arrival? YES NO
2. History of exposure to communicable disease? YES NO
3. Additions or corrections to information on this health history? YES NO
4. Medication given to health-care staff? YES NO

Provider Notes – *Include date/time/initial for all entries.*

Exit/Departure Note

Date: _____ Time: _____ Initials: _____

- ☐ Left this day with no reported illness or injury symptoms.
- ☐ Left this day with the following problem/concern:

This person was told about the problem and instructed about follow-up as noted above: _____