CAMP-of-the-WOODS Health Form

The purpose of having this health form is to assist CAMP-of-the-WOODS Health Care Staff in identifying appropriate care. This health form is ***required in order to work at Camp****. Health forms from last year are* ***not valid*** *for this year.*

STAFF INFORMATION (Please print clearly)

Name (Last)___________________________ (First)_______________ (M.I.)_____ Birth Date ___/___/___ Age at camp____

Current Address__________________________(City)____________________(State)_____(Zip)_________ Phone(___)_____________

Permanent Address_______________________(City)____________________(State)_____(Zip)_________ Phone(___)_____________

Social Security Number ____ Gender: ❑ Female ❑ Male

PARENT/GUARDIAN CONTACT

Name____ Relationship______________________

Phone (____)__________________ Cell Phone (____)__________________

Address_________________________________(City)____________________(State)_____(Zip)_________ Phone(___)_____________

EMERGENCY CONTACT (to be used if parent cannot be reached)

Name____ Relationship______________________

Phone (____)__________________ Cell Phone (____)__________________

Address_________________________________(City)____________________(State)_____(Zip)_________ Phone(___)_____________

Physician's Name:____ Phone(____)_________________________________

INSURANCE INFORMATION

Is the staffer covered by family medical/hospital insurance? ❑ Yes ❑ No

If so, indicate Insurance Company:____

Group #____ Prescription Plan #_______________________________________

Name of insured_____________________________________ Relationship to Staffer____________________________________

PLEASE INCLUDE A PHOTOCOPY OF HEALTH INSURANCE CARD TO BE USED IN THE EVENT THAT MEDICAL TREATMENT OR PRESCRIPTION IS REQUIRED.

Authorization and Permission to Provide Necessary Treatment or Emergency Care

(MUST be 18 or older to sign this section. If not 18, please have parent/guardian sign section below)

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 except as noted. I hereby give permission to the medical personnel selected by CAMP-of-the-WOODS to order X-rays, routine tests, and/or seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes and give my permission to arrange necessary related transportation for me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Nurse and/or his/her Assistant(s) to secure and administer treatment, including hospitalization, for the person named above. The completed form may be photocopied for trips out of camp.

Signature of Staffer____ **Date**______________________

Signature of Parent/Guardian____ **Date**______________________

ALLERGIES (List all known)

		Describe reaction and management of the reaction
Medication	**1.**	**1.**
	2.	**2.**
Food	**1.**	**1.**
	2.	**2.**
Other		
Other		

MEDICATIONS (List all currently taking)

Medication	Dosage	Specific times taken each day	Reason for taking
1.			
2.			
3.			
4.			

Explain any restrictions to activity

____

____

____

General Questions (Explain "yes" answers below)

Has/does the staffer:

#	Question	Yes	No
1.	Had any 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.	Ever had measles, chicken pox, german measles, or mumps?	❑	❑
16.	Ever been diagnosed with a heart murmur?	❑	❑
17.	Ever had back problems?	❑	❑
18.	Ever had problems with joints (ex. knees, ankles)?	❑	❑
19.	Have an orthodontic appliance being brought to camp?	❑	❑
20.	Have any skin problems (ex. itching, rash, acne)?	❑	❑
21.	Have diabetes?	❑	❑
22.	Have asthma?	❑	❑
23.	Had mononucleosis in the past 12 months?	❑	❑
24.	Had problems with diarrhea/constipation?	❑	❑
25.	Have problems sleeping walking?	❑	❑
26.	Have an abnormal menstrual history?	❑	❑
27.	Ever had an eating disorder?	❑	❑
28.	Ever had emotional difficulties for which professional help was sought?	❑	❑

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

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____

IMMUNIZATION HISTORY:

DPT or DR or TD	Date:__________	Date:__________	Date:__________	Date:__________	Date:__________
Polio	Date:__________	Date:__________	Date:__________	Date:__________	Date:__________
Tetanus	Date:__________				
Measles	Date:__________				
Mumps	Date:__________				
Rubella	Date:__________				
Chicken pox/varicella	Date:__________				
Haemophilus influenz B	Date:__________				
Hepatitis B	Date:__________				
Hepatitis A	Date:__________				
TB Mantous Test	Date of last Test:__________	❑ Positive	❑ Negative		

Use the space below to provide any additional information about the participant's behavior of which the camp should be aware.

____

____

____

____

Physical Examination - To be filled out by Physician

Staffer Name____ Date of Birth____/______/____
Last *First*

I have examined the above camp participant. Date of examination ___________________________

B/P__________ Weight__________ Height__________ Urine__________ Vision__________

Eyes:________________
Ears:________________
Nose:________________
Throat:________________
Heart:________________
Lungs:________________

Posture/Spine:_____________________
Skin:____________________________
Hernia:___________________________
Teeth:____________________________
Abdomen:_________________________

RECOMMENDATIONS WHILE AT CAMP:

Special Diet:____

Medications:

- ❑ This person takes NO medications on a routine basis.
- ❑ This person takes medications as follows:
(Any medication prescriptions must arrive in the original containers with the pharmacy label attached)

Medication	Dosage	Specific times taken each day	Reason for taking
1.			
2.			
3.			

Activity Restrictions/Limitations____

____

____

Additional Information for Health Care Staff:____

____

____

I have examined the patient herein described and have reviewed the health history. It is my opinion that this child is physically able to engage in the regular camp activities, except as noted.

Physician's Signature____ **Date:**________________

Please Print Name____ **Phone Number**___________________

Address____

Medical Health Release Form

NAME: _L_________________F_______________M.I______ M F DATE OF BIRTH ______________

ADDRESS:____
Number and Street City Zip Tel. #

LOCAL ADDRESS (If different):____
LOCAL PHONE:_______________ SOCIAL SECURITY #_________________ MARITAL STATUS:________
EMPLOYER:__________________________ WORK TEL #:_________________
OCCUPATION:____
Person to contact in case of Emergency:
RELATIONSHIP: ___________________________ HOME PHONE: _______________________

PERSON FINANCIALLY RESPONISBLE IF OTHER THAN PATIENT-
NAME:____ RELATIONSHIP TO PATIENT:_____________
DOB:__________ SS #:_____________ ADDRESS:____________________________________
TEL #________________ EMPLOYER:_________________________ WORK TEL #:_______________
OCCUPATION:____
REFFERING PHYSICIAN:___________________ PRIMARY CARE:__________________________
PHARMARY:___________________________
-PRIMARY INSURANCE:_______________ ID #:__________________ Grp #:_____________________
-SECONDARY INSURANCE:__________________ ID #:_______________ Grp #:___________________
I AUTHORIZE THE RELSEASE OF THE FOLLOWING TYPES OF INFORMATION TO THE FOLLOWING PEOPLE:
CAMP-OF-THE-WOODS ID ___________ APPT.: X BILLING: X MEDICAL: X
___________________ ID ___________ APPT.: _ BILLING: _ MEDICAL: _
___________________ ID ___________ APPT.: _ BILLING: _ MEDICAL: _
MAY WE IDENTIFY OURSELVES/ LEAVE MESSAGES ON YOUR ANSWERING MACHINE? _____ Y _____ N

ASSIGNMENT OF BENEFITS/RELEASE OF RECORDS

I HEREBY ASSIGN ALL MEDICAL AND/OR SUGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITSTO WHICH I AM ENTITLED, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH PLANS TO NATHAN LITTAUER CARE CENTER. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WEATHER OR NOT PAID BY SAID INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO BE RELEASE ANY INFORMATION NECESSARY TO SECURE SAID BENEFITS. I HEREBY AUTHORIZE NATHAN LITTAUER CARE CENTER TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENTS RENDERED TO MYSELF, OR TO MY SON/ DAUGHTER, TO MY REFERRING PHYSICIANS OR TO ANY OTHER PHYSICIAN FROM WHOM I SEEK MEDICAL TREATMENT. ADDITIONALLY, I HEREBY AUTHORIZE ANY OTHER PHYSICIANS WHO HAVE RENDERED SERVICES TO ME TO RELEASE TO NATHAN LITTAUER CARE CENTER SUCH INFORMATION AS THEY SHALL REQUEST TO ASSIST IN MY MEDICAL TREATMENT.

SIGNATURE:____ DATE_____________________

AUTHORIZATION FOR TREATMENT

I HEREBY AUTHORIZE THE MEDICAL CARE PROVIDERS AT NATHAN LITTAUER PRIMARY CARE CENTER TO RENDER MEDICAL CARE TO MYSELF OR THE ABOVE NAMED PERSON (LEGAL GUARDIANSHIP REQUIRED). I UNDERSTAND THAT SUCH MEDICAL CARE MAY INCLUDE HISTORY TAKING DIAGNOSTIC TESTING AND ADMINISTRATION OF MEDICATION. I UNDERSTAND THAT ANY TIMEI MAY DISCONTINUE TREATMENT OR PART THEREOF. INVASIVE PROCEDUES WILL REQUIRE A SEPARAFE AND DISTINCT AUTHORIZTION FOR TREATMENT WHICH INCLUDES INFORMED CONSENT OF SUCH PROCEDURE.

SIGNATURE:____ DATE_____________________