

—Staff Health History Form —

Information on this form is not part of the staff acceptance process but is gathered to assist us in identifying appropriate care. This form is to be filled out and signed by the parent or guardian if the staff member is under the age of 18. Staff members over 18 must complete and sign this form.

Last Name _____ First Name _____ Birth date _____ Sex _____

Parent(s) or Guardian(s) Name (First and Last) _____

Home Address _____ Preferred Phone () _____

Business Address _____ Phone () _____

Second Parent or Guardian or Emergency Contact (First and Last Name) _____

Home Address _____ Preferred Phone () _____

Business Address _____ Phone () _____

If none of the people mentioned above is available in an emergency, the Camp should notify:

Name _____ Relationship to my Child _____

Address _____ Preferred Phone () _____

Operations or serious injuries (dates) _____

Chronic or recurring illness or medical condition _____

Restrictions from Camp activities _____

Dietary restrictions (vegetarian, lactose intolerance) _____

Current medications (prescription & over-the-counter) _____

Name of dentist/orthodontist _____ Phone () _____

Name of family physician _____ Phone () _____

Do you carry family medical/hospital insurance? Yes No If so, Carrier: _____ Policy # _____

Date (month/year) of last tetanus shot? _____

For Female: Is menstrual history normal? Yes No Comments: _____

Health History: *The following health history is correct as far as I know, and the person herein described has no medical limitations that prevent him/her from engaging in all Camp activities related to his/her employment unless noted above under restrictions. I understand that if I am taking any medication that may impair my judgment or ability to perform my essential job functions that I must discuss this with the camp healthcare provider.*

(Check. Give approximate dates.)

_____ Frequent Ear Infections

_____ Heart Defect/Disease

_____ Seizures/Convulsions

_____ Diabetes

_____ Bleeding/Clot disorder

_____ Hypertension

_____ Mononucleosis

Other (Specify) _____

Diseases:

_____ Chicken Pox

_____ Measles

_____ German Measles

_____ Mumps

Allergies: (Dates not needed)

_____ Hay Fever

_____ Ivy Poisonings

_____ Insect Stings

_____ Penicillin

_____ Other Drugs

_____ Asthma

Other (Specify) _____

Authorization for Treatment: *I hereby give permission to the medical personnel selected by Brantwood Camp to dispense medications, provide routine healthcare, seek emergency treatments, order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for the employee named above. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Brantwood Camp to secure and administer treatment, including hospitalization, for the employee named above. The completed forms may be photocopied for trips out of camp. **Authorization for Release:** In the event of an emergency where I cannot be reached or am unable to pick up this employee, I hereby give Brantwood Camp permission to release this staff member to the person(s) named as the emergency contact(s).*

Signature of Staff Member (if over 18) _____ **Date** _____

Signature of Parent or Guardian _____ **Date** _____

(For Staff Members under the age of 18)