Staff Health History Form

Camp Albemarle

Dates of Employment: from ____________ to ____________
Month/ Day/ Year — Month/ Day/ Year

Name: ____
First — Middle — Last

☐ Male ☐ Female Birth Date ____________ Age on arrival at camp: ________

- Please complete pages 1-3; make copies for your records
- If staff member has medications; print out MAR Form and have MD fill out and signed
- Bring MAR Form to first day of staff training

Please return this form to:

Camp Albemarle 156 Albemarle Drive, Newport, NC 28570

Home Address: ____
Street Address — City — State — Zip Code

Parent/ guardian to be contacted in case of illness or injury

Name: ____________________ Relationship to staff: ______________ Preferred Phones (____)______________ (____)______________

Email: ____

Home Address: ____
Street Address — City — State — Zip Code

Second parent/ guardian or other emergency contact

Name: ____________________ Relationship to staff: ______________ Preferred Phones (____)______________ (____)______________

Email: ____

Additional contact in event parents(s)/ guardian(s) can not be reached:

Name: ____________________ Relationship to staff: ______________ Preferred Phones (____)______________ (____)______________

Email: ____

Allergies: ☐No known allergies Staff member is allergic to: ☐ Food ☐Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other

(Please describe below what the staff member is allergic to and the reaction seen)

Diet, Nutrition: ☐Staff member eats a regular diet ☐ Staff member eats a regular vegetarian diet

☐Staff member has special food needs **(please describe below)**

Restrictions:

☐ I have reviewed the program and activities and feel the staff member can participate without restrictions.

☐ I have reviewed the program and activities and feel the staff member can participate with the following restrictions or adaptations. **(please describe below)**

Medical Insurance Information:

This staff member is covered by medical/ hospital insurance ☐ Yes ☐ No

Include a copy of your health insurance card; copy/ scan both sides of the card so information is readable

Insurance Company ______________________ Policy Number ______________________

Subscriber ______________________________ Insurance Company Phone Number (____) __________________

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 activates except as noted by me and/ or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of the staff member for both routine health care and in emergency situations. If the parent/ guardian cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order in-jection, anesthesia, or surgery for this staff member. I understand the information on this form will be shared on a “need to know” basis with other camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of this staff members health record from providers who treat this staff member and these providers may talk with the program’s staff about the staff members health status.

Signature of Staff Member or Parent Guardian (if under 18)____ Date: ___________ Relationship to camper: ____________

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Name: ______________________________
First Middle Last

Birth Date: ________________
Month/ Day/ Year

Immunization History: Provide the month and year for each immunization. Starred (*) Immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach.

Immunization		Dose 1 Month/ Year	Dose 2 Month/ Year	Dose 3 Month/ Year	Dose 4 Month/ Year	Dose 5 Month / Year	Most Recent Dose Month/ Year
Diphtheria, tetanus, pertusis * (DTaP) or (TdaP)							
Tetanus booster* (dT) or (TdaP)							
Mumps, measles, rubella * (MMR)							
Polio * (IPV)							
Haemophilus influenza type B (HIB)							
Pneumococcal (PCV)							
Hepatitis B							
Hepatitis A							
Varicella (Chicken Pox)	☐ Had Chicken Pox Date:						
Meningococcal meningitis (MCV4)							

Tuberculosis (TB) Test	Date:	☐Negative ☐Positive

If staff member has not been fully immunized, please sign the following statement:
I understand and accept the risks to this staff member from not being fully immunized.

Signature of Staff Member or
Parent/ Guardian: (if under 18) ______________________________ Date: ____________ Relationship to camper: ________________

Medication: ☐ Staff Member will not take any daily medications while attending camp
☐ Staff Member will take daily medications while attending camp

If staff member is taking daily medications, please print out the MAR Form. Have a MD fill out and sign the form. Bring the completed form to the first day of staff training.

The following non– prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury.

Cross out those that should NOT be given.

Acetaminophen (Tylenol) or equivalent
Diphenhydramine antihistamine/ allergy medicine (Benadryl) Topical
Sore Throat Spray
Calamine lotion
Ibuprofen (Advil, Motrin) or equivalent
Generic cough drops
Antibiotic Cream (bacitracin)
Aloe
Bismuth subsalicylate for diarrhea (Pepto-Bismol)
Tums
Sunscreen
Swimmers Ear drops

I have read the above and understand that the staff member might be given the following medications unless otherwise noted.

Signature of Staff Member or
Parent Guardian (if under 18) ______________________________ Date: ________________

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Name: ______________________________
First   Middle   Last

Birth Date: ____________________
Month/ Day/ Year

General Health History: Check "Yes" or "No" for each statement. Explain the "Yes" answers below.

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 last year?	☐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/ join problems?...............................	☐Yes	☐ No
7. Have diabetes?...	☐Yes	☐ No	17. Have a 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 "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

Has the staff member:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/ hyperactivity (AD/HD) disorder?	☐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 even that continues to affect the staff members life?	☐Yes	☐No

(History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of primary doctor(s): ______________________________ Phone: (____) ____________________

Name of dentist(s): ______________________________ Phone: (____) ____________________

Name of orthodontist(s): ______________________________ Phone: (____) ____________________

What have we forgotten to Ask? Please provide in the space below any additional information about the staff member health that you think important or that may affect the staff member's ability to fully participate in the camp program.