



CAMP STAFF HEALTH HISTORY FORM

Page One: To Be Completed by Staff Member

Camp Location: _____

Your Name (Last/First/M.I.): _____ | _____ | _____

Birthdate: ____/____/____ Sex (circle one): Male Female

Permanent Address: _____ Phone#: _____

Emergency Contact #1 (Name/Phone #): _____ | _____

Emergency Contact #2 (Name/Phone #): _____ | _____

1) Please list any known allergies you have/have had in the past (medications, food, etc.):

2) Do you require any medication that might impair your ability to carry out the essential functions of your job during the summer (please choose one)?

YES NO

****If yes, you MUST discuss details of your medication with the Camp Health Director.*

3) Do you have any pre-existing medical conditions that might impair your ability to carry out the essential functions of your job during the summer (please choose one)?

YES NO

****If yes, you MUST discuss details of your medication with the Camp Health Director.*

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby authorize Camp Bed-Stuy to obtain necessary emergency medical treatment on my behalf. If deemed appropriate, Camp Bed-Stuy will also contact any listed emergency contact(s) in a timely manner.

Print Name: _____ Signature: _____ Date: _____

Page Two: MUST Be Completed (Signed & Stamped) By A Physician



CAMP STAFF HEALTH HISTORY FORM

HEALTH HISTORY

Full Name: _____ Birthdate: _____ Sex: M F

Check box if individual has ever had any of the listed afflictions, provide appropriate dates:

- Rheumatic Fever _____
- Seizures _____
- Diabetes _____
- Asthma _____
- Chicken Pox _____
- Other Past Illnesses (please list)
 - _____
 - _____
 - _____

Operations and/or Serious Injuries (dates): _____

Hospitalization (dates): _____

Chronic and/or Recurring Illness(es): _____

Appliance(s) Worn (glasses, contacts, etc.): _____

Prescription Medication Taken: _____

IMMUNIZATION HISTORY

*A copy of the individual's immunization records may be attached in lieu of completing this section.
This must include the dates (month/year) of all basic immunizations and most recent boosters.*

DTaP/DTP/Tdap/DT/Td	Date: _____	Date: _____	Date: _____
Polio	Date: _____	Date: _____	Date: _____
MMR	Date: _____	Date: _____	Date: _____
Hib	Date: _____	Date: _____	Date: _____
Hepatitis B	Date: _____	Date: _____	Date: _____
Varicella	Date: _____	Date: _____	Date: _____
PCV	Date: _____	Date: _____	Date: _____
Other: _____	Date: _____	Date: _____	Date: _____

PHYSICAL EXAM RESULTS

On the basis of my findings and with my knowledge of the above-named individual, I conclude that:

- 1) He/She is currently NOT exhibiting any signs or symptoms of a communicable disease that could be transmitted while working with children. YES | NO
- 2) He/She is currently NOT exhibiting any signs or symptoms suggestive of an emotional or psychological disorder that would hinder their ability to care for children. YES | NO
- 3) Is there any work-related activity from which the individual should be exempt or a limited participant in, due to health reasons? YES | NO

Exam Date: ____/____/____ Physician's Name (print): _____

Examining Physician (signature): _____ **PLEASE STAMP**



CAMP STAFF HEALTH HISTORY FORM

Page Three: To Be Completed by Staff Member if under the age of 18

Camp Location: _____

Your Name: _____

Birthdate: ____/____/____

Age: _____

Home Address: _____

Home Phone: _____

Personal Phone: _____

Parent/Guardian/Custodian Contact #1:

Name: _____

Home Address: _____

Personal Phone: _____

Work Phone: _____

Parent/Guardian/Custodian Contact #2:

Name: _____

Home Address: _____

Personal Phone: _____

Work Phone: _____



CAMP STAFF HEALTH HISTORY FORM

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby authorize Camp Bed-Stuy to obtain necessary emergency medical treatment on my child's behalf. If deemed appropriate, Camp Bed-Stuy will also contact any listed emergency contact(s) in a timely manner.

My relationship to staff member: _____

Print Name: _____ Signature: _____ Date: _____