HEALTH HISTORY FORM FOR CAMP EMPLOYEE

- *Please bring this health form with you and give it to the Health Center staff at camp.*
- *Notify the camp director if you are exposed to a communicable disease within three weeks of beginning your job.*
- *The camp expects that you arrive in good health and capable of performing the essential functions of your position. If you have concerns regarding this, speak with the camp director prior to arrival. Information on this form is available to Health Center staff and your work supervisor(s) as necessary.*

LAST NAME _____ FIRST NAME _____ ☐ MALE ☐ FEMALE

PERMANENT ADDRESS _____
Street Address City State Zip Code

PHONE NUMBER _____ EMAIL: _____

EMERGENCY CONTACT: *Who do you want us to contact in an emergency?*

First Contact: _____ Phone Number : _____ Relation to You: _____

Alternate Contact: _____ Phone Number : _____ Relation to You: _____

Name of your physician: _____ Office Phone _____

Name of your dentist/orthodontist: _____ Office Phone _____

ALLERGIES: *Check those that apply to you. Completion of this section is voluntary, yet helpful to healthcare staff.*

☐ I have no known allergies.

☐ I have an allergy to this food: _____ This causes anaphylaxis? ☐ Yes ☐ No

Describe what happens if you eat this food and how the reaction is managed: _____

☐ I am allergic to this medication(s): _____ This causes anaphylaxis? ☐ Yes ☐ No

☐ I am allergic to these substances: _____ This causes anaphylaxis? ☐ Yes ☐ No

Describe what happens if you are exposed to these medications or substances and how the reaction is managed: _____

_____

CHRONIC CONCERNS: *Check all that pertain to you and provide information about supportive healthcare. Completion of this section is voluntary, yet helpful to healthcare staff.*

☐ I have no chronic health concerns. ☐ I have the following chronic health concern(s):

☐ Asthma ☐ Headaches, Migraines ☐ Sleep problem ☐ Diabetes ☐ Difficulty breathing

☐ Dysmenorrhea ☐ Fainting ☐ Surgical history ☐ Seizure disorder: _____

☐ Back pain or injury ☐ Knee or ankle weakness ☐ Other: _____

IMMUNIZATION HISTORY: Date (month/year) of your most recent tetanus immunization: _____ **THIS IS REQUIRED.**

Have you completed the immunizations that were required for school attendance? . . . . . ☐ Yes ☐ No

MEDICATION: All medications must be kept in the clinic. *All medication must be locked securely unless in the immediate possession/control of the user. If medication might impair your ability to perform the essential functions of your job please discuss with the Clinic staff.*

Medication #1 _____ Medication #2 _____ Medication #3 _____

NUTRITION:

☐ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.

☐ I am a vegetarian of this type:

- ☐ Semi-vegetarian (no pork or beef)
- ☐ Pesco (no pork, beef, or chicken)
- ☐ Lacto (no meats, fish, seafood, or eggs)
- ☐ Ovo (no meats, fish, seafood, or dairy)
- ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
- ☐ Vegan (no meats, seafood, eggs, or dairy)

GENERAL PHYSICAL HISTORY: *If you answer "Yes" to any of these questions, provide more information at the end of this section.*

Completing this session is voluntary, but helpful to healthcare staff.

1. Have you ever been hospitalized? . . . . . ☐ Yes ☐ No
2. Have you ever passed out during or after exercise? . . . . . ☐ Yes ☐ No
3. Have you ever been dizzy during or after exercise? . . . . . ☐ Yes ☐ No
4. Have you ever had chest pain during or after exercise? . . . . . ☐ Yes ☐ No
5. Do you tire more quickly than your friends during exercise? . . . . . ☐ Yes ☐ No
6. Have you ever had high blood pressure? . . . . . ☐ Yes ☐ No
7. Have you ever had a racing heartbeat or skipped heartbeats? . . . . . ☐ Yes ☐ No
8. Have you ever been knocked out or become unconscious? . . . . . ☐ Yes ☐ No
9. Have you ever had a seizure? . . . . . ☐ Yes ☐ No
10. Have you ever had a stinger, burner, or pinched nerve? . . . . . ☐ Yes ☐ No
11. Have you ever had heat or muscle cramps? . . . . . ☐ Yes ☐ No
12. Have you ever been dizzy or passed out in the heat? . . . . . ☐ Yes ☐ No
13. Have you ever sprained, strained, dislocated, fractured, broken or had repeated swelling, or other injuries to any of your body areas? . . . . . ☐ Yes ☐ No

    If so, where? ☐ Head ☐ Shoulder ☐ Leg ☐ Neck ☐ Chest
    ☐ Arm, hand ☐ Ankle ☐ Back ☐ Hip ☐ Foot
14. Have you been in countries other than the United States in the past nine months? . . . . . ☐ Yes ☐ No

If yes, list the countries and the time spent in them.

Country: _____ Dates: _____

Country: _____ Dates: _____

Country: _____ Dates: _____

Use the space below to explain and/or provide more detail about the General Physical Health questions to which you responded "Yes."

_____ _____

_____ _____

PAYING FOR HEALTH CARE

There is no charge for healthcare provided by the camp's Health Center staff. You are financially responsible for healthcare provided by all other providers. If you will be using personal insurance while working at camp, know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

AUTHORIZATION FOR HEALTHCARE: *Parental signature required for staff under 18 years of age.*

This health history is correct. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp's Health Center staff in providing care to me and may be reviewed by my work supervisor(s).

Staff Signature: _____ *Date:* _____ *Parental Signature (if needed):* _____ *Date :* _____

AUTHORIZATION TO TREAT

I hereby give permission for Hermann Sons Life Camp and medical personnel selected by the Camp to provide routine health care; to administer medication, including any over-the-counter medications Camp medical personnel deem necessary; to order tests, X-rays and treatment; to release any records necessary for reporting purposes; and to provide or arrange any necessary transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician and health care facility selected by the Camp to secure and administer treatment, including hospitalization, for the person named in this document. I also attest that all information included in this form is correct and accurately reflects the health status of the camper to whom it pertains, so far as I know, and the person described has permission to engage in all Camp activities unless otherwise noted. 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.

Staff Signature: _____ *Date:* _____ *Parental Signature (if needed):* _____ *Date :* _____

If you have questions about our camp health services, please call our office at 830.995.3223.