MEDICAL: Health History and Examination Form for Camp Staff Applicants

Pages 1 – 3 should be completed by Applicant or guardian, if a minor.
Submit with Examination Form to your physician for review.

Applicant Last Name: ____________________ **Applicant First Name:**_______________________ **MI:**________

Date of Birth:________________ Age:_______ Gender: ☐ Male ☐ Female

Address: ____

____

____

First Preferred Telephone Number:_____________________ Second Preferred Telephone Number:________________

Custodial Parent/Guardian Information (If under 18 years old) Full Name:____________________________________

Preferred Telephone Number:______________________ Business Telephone Number:________________

Address: (If different from above) ____

____

____

EMERGENCY CONTACT:

Name: __________________________________ Relationship: _______________ Phone: ____________________

MEDICAL INSURANCE INFORMATION: ➔ **Please include a copy of current Insurance Card (if applicable).**

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

Name of Insured: ____________________________ Insurance Co.:____________________________________

Group or Policy #: ___________________________ Carrier Phone Number:_____________________________

APPLICANT (OR PARENT/GUARDIAN) AUTHORIZATIONS

(*if for religious reasons you cannot sign this form, contact the camp for a legal waiver, which must be signed for attendance.)*

This health history is correct and complete as far as I know, and the person herein described has permission to work or participate in all camp activities except as noted. I give permission to camp medical staff to provide the non-prescription medications as needed based on the options selected herein.

Permission to Provide Necessary Treatment or Emergency Care:

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Meningitis Vaccination Response

If I am or my child is going to work in a camp setting, I confirm that I have read, or have had explained to me, the enclosed information about meningitis vaccination. If I choose not to have myself or my child vaccinated, I confirm that I understand the risk of not receiving the vaccine.

If a minor, I also understand and agree to abide by the restrictions placed on my work, participation and camp activities.

Signature of Participant: ___________________________ **Printed**: ___________________________ **Date**: _______________

Signature of Parent/Guardian (if minor): ___________________ **Printed**: ________________________ **Date**: ______________

MEDICAL: Health History

RESTRICTIONS
Dietary:

☐ Does not eat red meat ☐ Does not eat poultry ☐ Does not eat dairy products
☐ Does not eat pork ☐ Does not eat seafood ☐ Other: ___________________
☐ Does not eat eggs ☐ Gluten Intolerance

Please explain: ____

____

Activity/Assignment Restrictions:

Based on the job description for the applicant's position, please clarify any camp or work activities from which the applicant should be exempted or limited for health reasons and explain any physical limitations: ___________________

____

____

____

GENERAL QUESTIONS

Please check "Y" for Yes or "N" for No to answer each question about medical history.

1. Had any recent injury, illness, or infectious diseases?	☐ **Y** ☐ **N**	11. Ever had seizures?	☐ **Y** ☐ **N**
2. Have a chronic or recurring illness/condition?	☐ **Y** ☐ **N**	12. Ever had high blood pressure?	☐ **Y** ☐ **N**
3. Ever been hospitalized?	☐ **Y** ☐ **N**	13. Ever been diagnosed with a heart murmur?	☐ **Y** ☐ **N**
4. Ever had surgery?	☐ **Y** ☐ **N**	14. Ever had back or joint problems?	☐ **Y** ☐ **N**
5. Have frequent headaches?	☐ **Y** ☐ **N**	15. Have any skin problems (e.g., itching rash, acne)?	☐ **Y** ☐ **N**
6. Ever had a head injury or been knocked unconscious?	☐ **Y** ☐ **N**	16. Have diabetes?	☐ **Y** ☐ **N**
7. Wear glasses, contacts, and protective eyewear?	☐ **Y** ☐ **N**	17. Have asthma?	☐ **Y** ☐ **N**
8. Ever had frequent ear infections?	☐ **Y** ☐ **N**	18. Had mononucleosis in the past 12 months?	☐ **Y** ☐ **N**
9. Ever passed out during or after exercise?	☐ **Y** ☐ **N**	19. Had problems with diarrhea/constipation?	☐ **Y** ☐ **N**
10. Ever had dizziness or chest pain during or after exercise?	☐ **Y** ☐ **N**	20. If female, have an abnormal menstrual history?	☐ **Y** ☐ **N**

Explain "Y" answers, noting corresponding number:

____

____

____

ALLERGIES

Does the applicant have allergies? ☐ **Yes** ☐ **No** Fill in what the applicant is allergic to, reaction and authorized management

Medication allergies: ____

Food allergies: ____

Other – insect stings, hay fever, etc.: ____

Does the applicant require an Epi-pen: ☐ **Yes** ☐ **No** If **'Yes'** Epi-pen must be brought by applicant to camp.

MEDICAL: Health History

NON-PRESCRIPTION MEDICATION

Homes for the Homeless Summer Camps generally has the following non-prescription medications available at the camp infirmary. Please check 'Yes' or 'No' next to all non-prescription medications that may be dispensed to you/your child at camp. Participant will be given the recommended dosage, which corresponds to their age and/or weight as per label instructions.

Medication (or equivalent)	Symptoms Treated	Can be used	Comments
Tylenol	Headache, Aches, Cramps	☐ **Yes** ☐ **No**	
Ibuprofen	Headache, Aches, Cramps	☐ **Yes** ☐ **No**	
Cough Syrup	Cough	☐ **Yes** ☐ **No**	
Cough Drops	Cough	☐ **Yes** ☐ **No**	
Visine	Red, Irritated Eyes	☐ **Yes** ☐ **No**	
Antifungal Cream/Spray	Itchy, Burning Feet	☐ **Yes** ☐ **No**	
Pepto-Bismol	Upset Stomach	☐ **Yes** ☐ **No**	
Kaopectate	Antidiarrheal	☐ **Yes** ☐ **No**	
Maalox	Antacid	☐ **Yes** ☐ **No**	
Rolaids	Antacid	☐ **Yes** ☐ **No**	
Antihistamines	Allergy	☐ **Yes** ☐ **No**	
Anbesol	Toothache	☐ **Yes** ☐ **No**	
Triple Antibiotic Ointment	Abrasions/Cuts	☐ **Yes** ☐ **No**	
Bengay	Sore Muscles	☐ **Yes** ☐ **No**	
Chloraseptic Spray	Sore Throat	☐ **Yes** ☐ **No**	
Solarcaine	Sunburn	☐ **Yes** ☐ **No**	

Note: The camp infirmary **WILL NOT** provide you/your child with any treatment not check off as "Yes."

ROUTINE MEDICATION

Please list **ALL** medications (including over-the-counter/ non-prescription drugs) taken routinely. Please check one below.

☐ This person takes **NO** medication on a routine basis
☐ This person takes medication as follows:

Medication	Dosage	Frequency	Reason For Taking
1.			
2.			
3.			

IMMUNIZATIONS

Please confirm date (month and year) of last tetanus shot: Year:_________________ Month: _____________________

➔ A copy of participant's **completed immunization records** must be submitted or have doctor fill in page 4

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR/HEALTH CARE PROVIDER

MEDICAL: Physical Examination

Applicant's Last Name:_________________________ First Name: _______________________________

D.O.B:______________ Age:________ Gender: ☐ M ☐ F BP: ___________ Weight:___________ Height:________

The applicant is under the care of a physician for the following conditions:

____

Any medically prescribed meal plan or dietary restrictions:____

Known allergies:____

Describe any limitation or restriction on camp activities:____

<u>RECOMMENDATIONS AND RESTRICTIONS AT CAMP</u>

Please list **ALL** medications (including over-the-counter/ non-prescription drugs) taken routinely. Please check one below.

☐ This person takes **NO** medication on a routine basis
☐ This person takes medication as follows:

Medication	Dosage	Frequency	Reason For Taking
1.			
2.			
3.			

IMMUNIZATION (Attach copy of official immunization record as well)

Please give all dates in Month and Year of immunization for:

Vaccine	**Date:** MM/YY	MM/YY	MM/YY	MM/YY	MM/YY	MM/YY
DTP	______	______	______	______	______	______
DT (Diphtheria/Tetanus)	______	______	______	______	______	______
Polio	______	______	______	______	______	______
Tetanus	______	______	______	______	______	______
Hepatitis B	______	______	______			
Haemophilus Influenza B	______	______	______			
MMR	______	______				
Measles	______	______		Mumps	______	______
Rubella	______	______				
Varicella (chicken pox)	______	______				
Meningococcal (Meningitis)	______	______				
Human Papillomavirus (HPV)	______	______				
Hepatitis A (HEP A)	______	______				

MUST BE COMPLETED, SIGNED AND STAMPED BY DOCTOR/HEALTH CARE PROVIDER

TB Mantoux Test: Date of test:____________________ Result: ☐ Negative ☐ Positive

Additional Comments:____

DISEASE HISTORY

Which of the following illnesses has the participant had?

☐ Measles ☐ Chicken Pox ☐ German measles ☐ Mumps ☐ Hepatitis ☐ Varicella Zoster

PHYSICIAN AUTHORIZATIONS

Name of Applicant's Physician:_______________________________________ Phone:_________________________

Address:____

Name of Applicant's Dentist:____ Phone:______________________

Address:____

Physician/Health Care Provider's Statement:

"I have examined _______________________________________ and discussed the applicant's health history with the
Print Applicant's Name

applicant or the applicant's parent/guardian. In my opinion the above applicant is able work and participate in an active camp program. I hereby give permission to Homes for the Homeless Summer Camps medical staff to provide the above mentioned non-prescribed and prescribed medications to this applicant as needed."

MANDATORY

Printed:________________________________ **Signature of Physician/Provider:**_________________________

Title:________________________________ **Date of Examination**:__________________________

Medical Office/Physician stamp *REQUIRED* here

For camp use only

Screening Record

Date screened:_____________________ Time:_______________am / pm Screened by____

Meds received____

Updated/additions to health history noted: Yes No None required

Current health needs identified:____

Observational notes:____

Meningococcal Meningitis

This insert is for informational purposes only, and is referred to on Page 1 of the Medical: Health History and Examination Form. Please read it carefully, and then keep this sheet for your records.

Meningococcal disease is a potentially fatal bacterial infection commonly referred to as meningitis. New York State Public Health Law (NYS PHL) §2167 requires overnight children's camps to distribute information about meningococcal disease and vaccination to the parents or guardians for all campers who attend camp for 7 or more nights. We choose to include applicants for employment.

Homes for the Homeless Summer Camps is required to maintain a record of the following for each camper and we choose to also cover all staff:

- A response to receipt of meningococcal meningitis disease and vaccine information signed by the applicant (or their parent or guardian); AND EITHER
- A record of meningococcal meningitis immunization within the past 10 years; OR
- An acknowledgement of meningococcal meningitis disease risks and refusal of meningococcal meningitis immunization (see page 1) signed by applicants for employment (or by their parent or guardian, if under 18 years old).

We want to make you aware of meningococcal meningitis and document on page 1 your decision to either decline or seek out the vaccination.

Meningococcal Meningitis

Meningitis is rare. However, when it strikes, its flu-like symptoms make diagnosis difficult. If not treated early, meningitis can lead to swelling of the fluid surrounding the brain and spinal column as well as severe and permanent disabilities, such as hearing loss, brain damage, seizures, limb amputation, and even death.

Cases of meningitis among teenagers and young adults ages 15 to 24 have more than doubled since 1991. The disease strikes about 3,000 Americans each year and claims about 300 lives.

A vaccine is available that protects against four types of the bacteria that cause meningitis in the United States—types A, C, Y, and W-135. These types account for nearly two thirds of meningitis cases amongst teenagers and young adults.

Information about the availability and cost of the vaccine can be obtained from your health care provider and by visiting the manufacturer's website at www.meningitisvaccine.com.

To learn more about meningitis and the vaccine, please consult a physician. You can also find information about the disease on the Web sites of the New York State Department of Health, www.health.state.ny.us, and the Centers for Disease Control and Prevention, www.cdc.gov/ncidod/dbmd/diseaseinfo.

HFH Summer Camps