

Health History Form for Camp Staff



Name: _____
First Middle Last

Sex: Male Female Birth Date _____

Age: _____ SS Number _____

Permanent Address: _____

Home Phone: _____ Cell: _____

Country of Residence _____

E-mail: _____

Emergency Contact: _____

Relationship: _____

Phone: _____ Cell: _____

Emergency Contact: _____

Relationship: _____

Phone: _____ Cell: _____

The information in this form is to assist your camp healthcare provider in identifying appropriate care. Please return this form at least four weeks before you arrive. People hired within two weeks of their start date should bring it with you rather than sending it.

- Copy the completed form for your records; note changes that occur and inform the camp healthcare provider upon arrival.
- Notify the camp director if you are exposed to a communicable disease within two weeks of your job.
- The camp administration expects that you arrive in good health and capable of doing the job for which you were hired.

Your start date: _____

Your Position Title: _____

Questions about camp health services can be answered by the Director/Program Director by calling _____

Allergies: Check those that apply to you.

_____ I have no known allergies.
 _____ I have an allergy to this/these food/s: _____

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

_____ I am allergic to this medication/s: _____
 _____ I am allergic to these substances: _____

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

Chronic Concerns: Check all that pertain to you and provide information about supportive healthcare.

_____ I have no chronic health concerns
 _____ I have the following chronic health concern/s:
 Asthma Headaches/Migraines Sleep Problem
 Diabetes Difficult Breathing Dysmenorrhea
 Fainting Surgery History Seizure disorder: _____
 Back Pain or injury Knee or ankle weakness Other: _____

Provide information about supportive healthcare needed for each checked item: _____

Nutrition: Our expectation is that staff set an example for campers by eating the provided menu. The camp kitchen can work effectively with some medically prescribed diets but does not cater to individual preferences.

_____ I eat a regular, varied diet.
 _____ I am lactose-intolerant. Be prepared to manage your intolerance using products such as Lactaid or food avoidance.
 _____ I am a vegetarian.
 _____ I respond with an anaphylactic reaction when I eat this food: _____

Provide information about supportive healthcare needed for each check item: _____

Position: _____

Last

First

Name: _____

Medication: *Bring enough medication for your entire stay. Prescription meds MUST be in pharmacy containers with appropriate labels; other remedies must be in original container. All medication will be stored in the camp Health Center. International staff: translate medication information to English before leaving your country.*

_____ I do not take medication on a routine basis.

_____ I take routine medication (include vitamins) as follows: (attach more information if needed)

Name of medication: _____
 Reason for taking: _____
 Dose Taken: _____
 Times: _____

Name of medication: _____
 Reason for taking: _____
 Dose Taken: _____
 Times: _____

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 Dose Taken: _____
 Times: _____

Name of medication: _____
 Reason for taking: _____
 Dose Taken: _____
 Times: _____

Name of medication: _____
 Reason for taking: _____
 Dose Taken: _____
 Times: _____

Name of medication: _____
 Reason for taking: _____
 Dose Taken: _____
 Times: _____

General Physical History

- 1. Have you ever been hospitalized? Yes No
 Have you ever had surgery? Yes No
- 2. Have you ever passed out during or after exercise? Yes No
 Have you ever been told that you have a heart murmur? Yes No
 Have you ever had high blood pressure? Yes No
 Have you ever had racing of your heart or skipped a heart beat? Yes No
- 3. Do you have skin problems (itching, rashes, acne)? Yes No
- 4. Have you ever been knocked out or unconscious? Yes No
 Have you ever had a seizure? Yes No
- 5. Have you ever had heat or muscle cramps? Yes No
 Have you ever been dizzy or passed out in the heat? Yes No
- 6. Have you had the chicken pox or are you immunized for chicken pox? Yes No
- 7. Have you had mononucleosis in the past nine months? Yes No
- 8. Do you have a hearing problem? Yes No
 Do you have a vision (sight) problem? Yes No
 Do you wear glasses or contacts or use protective eye wear? Yes No
- 9. Do you typically make noise while sleeping (i.e. snore, talk in sleep, etc.) ? Yes No
- 10. Do you have any problems with your teeth? Yes No
- 11. 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 Thigh Neck Chest
 Forearm Shin/calf Back Wrist Hand
 Ankle Elbow Knee Hip Foot
- 12. Do you smoke and/or use other tobacco products? Yes No
- 13. Do you have any piercing? Yes No
 If so, where? Ears Eyebrow Nose Tongue
 Belly Button Nipple Other: _____
- 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 length of time spent in them.
 Countries: _____ Dates: _____
 Countries: _____ Dates: _____
 Countries: _____ Dates: _____
 Countries: _____ Dates: _____
- 15. For women: Do you have a menstrual problem (pain, irregularity, etc.) ? Yes No

Explain and/or provide more detail about the General Physical Health questions to which you responded "yes".

 # _____
 # _____
 # _____
 # _____

Mental and Emotional Health Information

- A. Have you been diagnosed with attention deficit (ADD) or AD/HD? Yes No
- B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder? Yes No
- C. Do you have an eating disorder? Type: _____ Yes No
- D. Do you have a learning disability? Type: _____ Yes No
- E. Do you have an emotional health concern? Yes No
- F. During the past year, have you seen a professional about mental/emotional concerns? Yes No

If yes to any question in this section, attach a statement that:

- (a) Describes the concern and your management plan for addressing it while working at camp; and
- (b) Describes the support needed from your work supervisor to compliment your plan.

Immunization History: Provide the month and year for immunizations. Starred (*) immunizations must be current.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis				
*Td: Tetanus Booster	Must be current within past ten years.			
*MMR: Mumps, Measles, Rubella				
*IVP/OPV: Polio				
HepB: Hepatitis B				
Hib: H. influenzae, type b				

Name of your **physician** _____ Office Phone _____

Name of your **dentist/orthodontist** _____ Office Phone _____

Paying for Health Care:

- There is no charge for healthcare provided by the camp's Health Center Staff.
- Staff are financially responsible for healthcare provided by all other providers.
- If you will be using personal insurance while working at our program, it is your responsibility to know how to access that insurance. **Bring your insurance card with you;** obtain pre-authorization if your insurance requires this.

Authorization for Healthcare: *Parental signature for staff under 18 years of age.*

This health history is correct insofar as I know. I am capable of performing the essential functions of my job and participating in assigned activities except as noted on this form. I understand my health information will be used by the camp's Health Staff in providing care to me and may be reviewed by the camp director.

I give the camp health staff permission to give me over the counter and prescription medications in accordance with the standing orders approved by the camp physician. I hereby give permission to the medical personnel selected by the Camp Director to order X-rays, routine tests and treatment for me/my child, and in the event I cannot be reached in an emergency, I hereby give permission to the medical personnel selected by the Camp Director to hospitalize, secure proper treatment, review my/my child's medical records, discuss my/my child's conditions with any medical personnel, and to order injection and anesthesia and/or surgery for me/my child as named above. This form may be photocopied for use out of the camp. This form is a HIPAA authorization release.

I give permission for me/my child to be transported in private vehicle if necessary.

I release all photos, videos and audio tapes of me to Detroit Conference Outdoor and Retreat Ministries to be used for promotional purposes. I acknowledge that post camp meetings, reunions, and voluntary events are not conducted under the supervision or auspices/sponsorship of the BORM, which is not responsible for anyone's well-being at such events.

Signature of Staff Member: _____ Date: _____

Signature of parent (if needed): _____ Date: _____

