HFH Summer Camps
WAKONDA LANOWA

american camp association ACCREDITED

MEDICAL FORM: Health History and Examination Form for Camp Staff Applicants

APPLICANT: Complete pages 1 – 3. Submit with Examination Form to your physician for review.

First Name: _____ **Last Name:** _____ **MI**:_____

Date of Birth: _____ **Age:** _____ **Gender:** ☐ Male ☐ Female

Address: _____

_____

Preferred Telephone Number: _____ **Second Telephone Number**: _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____ Phone: _____

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: _____

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.			
4.			

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 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 If yes, 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.**

NON-PRESCRIPTION MEDICATION

HFH 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 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	
Solar Caine	Sunburn	☐ Yes ☐ No	

Note: The camp infirmary <u>WILL NOT</u> provide you with any treatment not check off as "Yes."

APPLICANT AUTHORIZATIONS: (*if for religious reasons you cannot sign this form, contact the HR department for a legal waiver)*

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. I hereby give permission to the physician to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied if needed.

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

Signature of Participant: _____ Printed: _____ Date: _____

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

MEDICAL: PHYSICAL EXAMINATION FORM

Applicant's First Name:_____ **Last 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:_____

Which of the following has the participant had a history of?

☐ ADD/ADHD ☐ Seizures ☐ Heart Disease ☐ Diabetes ☐ Lyme Disease ☐ Mood Disorder ☐ ODD

Does the participant have Asthma? ☐ Yes ☐ No If *yes,* ☐ Intermittent ☐ Mild persistent ☐ Moderate persistent ☐ Severe persistent

Does the participant have an Asthma Action Plan? ☐ Yes ☐ No *If Yes, please provide a copy or complete the action plan attached*

ROUTINE MEDICATION

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

☐ This person takes <u>NO</u> medication on a routine basis
☐ This person takes medication as follows:

Medication	Dosage	Frequency	Reason for Taking
1.			
2.			
3.			
4.			

DISEASE HISTORY

Which of the following illnesses has the participant had?

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

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

IMMUNIZATIONS

Provide the month and year for each immunization. Starred (*) immunizations must include Month, Day and Year. Copies of immunization forms from health-care providers or state or local government are acceptable. **Please note all participants must have all immunizations required by NY State in order to work at camp and must have received two doses of the MMR vaccinations in order to work at camp.**

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, pertussis (DTaP) or (TdaP)							
Tetanus booster* (dT) or (TdaP) (Month/Day/Year)							
Mumps, measles, rubella* (MMR) (Month/Day/Year)							
Polio (IPV)							
Haemophilus influenzae type B (HIB)							
Pneumococcal (PCV)							
Hepatitis B							
Hepatitis A							
Meningococcal meningitis (MCV4)							
Varicella (chicken pox)	☐ Had chicken pox Date:						
Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive				

PHYSICIAN AUTHORIZATION

Name of Applicant's Physician:_____ Phone:_____

Address:_____

PHYSICIAN/HEALTH CARE PROVIDER'S STATEMENT

"I have examined _____and discussed the applicant's health history with the applicant. In my opinion the above applicant is able work and participate in an active camp program. I hereby give permission to HFH Summer Camps medical staff to provide the above mentioned non-prescribed and prescribed medications to this applicant as needed."

MANDATORY Printed:_____ **Date of Examination:**_____

Signature: _____

Title:_____

Stamp *REQUIRED*

***For Camp use* - 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:_____

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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. HFH 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

HFH Summer Camps

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.