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: Ahmed **Last Name:** Saad **MI:** A

Date of Birth: 12/09/1997 **Age:** 22 **Gender:** ☑ Male ☐ Female

Address: Grinfel Street , New Police Buildings , Alexandria , Egypt 21517

Preferred Telephone Number: 002 03 39 50 777 **Second Telephone Number:** 002 01023034581

EMERGENCY CONTACT:

Name: Nehad El behiry Relationship: Mother Phone: 002 010 23766659

Name: Juliana Cuzzi Relationship: friend Phone: +1 347-809-1060

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: AAST 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. Aramays	~~once a day~~ one Pump	once a day	Dust, Smoke Allergies
2.			
3.			
4.			

RESTRICTIONS

Dietary:

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

Please explain: Religion.

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: None.

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:
7- Corrects my vision but can do fine without. 10- happened once.
12- had high blood pressure multiple times but not diagnosed.

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: Ahmed saad Date: 02/18/2020

HFH Summer Camps
WAKONDA LANOWA

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

MEDICAL: PHYSICAL EXAMINATION FORM

Applicant's First Name: Ahmed **Last Name:** Saad

D.O.B: 12/09/1997 **Age:** 22 **Gender:** ☑ M ☐ F **BP:** _____ **Weight:** 91 Kgs **Height:** 170 cm

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

_____

_____

Any medically prescribed meal plan or dietary restrictions: No

Known allergies: No

Describe any limitation or restriction on camp activities: No

Which of the following has the participant had a history of? None

☐ 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 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. No			
2.			
3.			
4.			

DISEASE HISTORY

Which of the following illnesses has the participant had?

No ☐ Measles ☑ Chicken Pox No ☐ German measles No ☐ Mumps No ☐ Hepatitis No ☐ 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)		02/2002	02/2002				
Tetanus booster* (dT) or (TdaP) (Month/Day/Year)							01/1998
Mumps, measles, rubella* (MMR) (Month/Day/Year)		01/05/1998	02/02/1998				
Polio (IPV)		2/1998	4/1998	6/1998			
Haemophilus influenzae type B (HIB)							
Pneumococcal (PCV)		01/1998	03/1998	05/1998			
Hepatitis B		2/1998	4/1998	6/1998			
Hepatitis A		5/2014	6/2016				
Meningococcal meningitis (MCV4)		5/2014					
Varicella (chicken pox)	☑ Had chicken pox Date:	05/2010	06/2010				
Tuberculosis (TB) test	Date: 01/2005	☑ Negative	☐ Positive				

PHYSICIAN AUTHORIZATION

Name of Applicant's Physician: Dr Hani Abou shama Phone: 49 59 399

Address: 89 Arfan Street multan pak

PHYSICIAN/HEALTH CARE PROVIDER'S STATEMENT

"I have examined Ahmad Saad 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:** Hani Abou shama **Date of Examination:**

Signature: Dr Hani Abou shama

Title: –

هانی محمد ابو شامه دکتور استشاری اول طب طوارئ باطنة - قلب

26/2/2020

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:_____