BADGER DAY CAMP

Staff Medical Form

PLEASE PRINT. FILL OUT AS COMPLETELY AS POSSIBLE.

DISCLAIMER

DISCLAIMER: THE INFORMATION THAT YOU PROVIDE ON THIS FORM IS NOT IN ANY WAY AFFILIATED WITH THE ACCEPTANCE PROCESS IF THE STAFF MEMBERS. THIS INFORMATION IS EXCLUSIVELY PROVIDED TO AID IN THE INDIVIDUAL CARE IF EACH STAFF MEMBER. PARENTS/GUARDIANS MUST FILL OUT THIS FORM IF THE STAFF MEMBER IS UNDER THE AGE OF 18.

NAME _____ AGE _____
Last First Middle

HOME ADDRESS _____ STATE _____ ZIP _____
Street Address City

FIRST PARENT/GUARDIAN

NAME _____
Last First Middle

HOME ADDRESS _____ STATE _____ ZIP _____
(if different) Street Address City

BUSINESS ADDRESS _____ STATE _____ ZIP _____
Street Address City

CELL PHONE _____ HOME PHONE _____

WORK PHONE _____ ADDITIONAL PHONE _____

SECOND PARENT/GUARDIAN

NAME _____
Last First Middle

HOME ADDRESS _____ STATE _____ ZIP _____
(if different) Street Address City

BUSINESS ADDRESS _____ STATE _____ ZIP _____
Street Address City

CELL PHONE _____ HOME PHONE _____

WORK PHONE _____ ADDITIONAL PHONE _____

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EMERGENCY CONTACTS

NAME _____ RELATIONSHIP _____
Last First

CELL PHONE _____ HOME PHONE _____

WORK PHONE _____ ADDITIONAL PHONE _____

NAME _____ RELATIONSHIP _____
Last First

CELL PHONE _____ HOME PHONE _____

WORK PHONE _____ ADDITIONAL PHONE _____

NAME _____ RELATIONSHIP _____
Last First

CELL PHONE _____ HOME PHONE _____

WORK PHONE _____ ADDITIONAL PHONE _____

INSURANCE INFORMATION

Indicate if staff member is covered by family medical/hospital insurance **YES** **NO**

If yes, please indicate carrier or plan name: _____

Group # _____ Phone: _____

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ALLERGIES

FOOD ALLERGIES	REACTION

MEDICAL ALLERGIES	REACTION

OTHER ALLERGIES	REACTION

If it is necessary please provide any additional information about the staff members behavior, and their physical, emotional and mental health. **Rest assured that all information provided will be kept confidential.**

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MEDICATIONS

- ✓ All medications must be accompanied by a doctor's order.
- ✓ All medications are stored/administered by camp nurse.
- ✓ Keep medications in original packaging that identifies the prescribing physician, the name of the medication, dosage and frequency of administration.

Do you take any medication that might impair your ability to perform the essential functions of your position? **YES** **NO**

If yes, please be prepared to discuss the details with the camp nurse. Disclosure of such information will be treated with the strictest of confidence and be shared on a specific need-to-know basis.

RESTRICTIONS

Please indicate if the staff member has any dietary restrictions or restrictions to activities:

_____

_____

GENERAL QUESTIONS

Have a chronic or recurring illness/condition?	**YES**	**NO**
Ever been hospitalized?	**YES**	**NO**
Ever passed out during or after exercise?	**YES**	**NO**
Ever been dizzy during or after exercise?	**YES**	**NO**
Ever had seizures?	**YES**	**NO**
Ever had chest pain during or after exercise?	**YES**	**NO**
Ever had high blood pressure?	**YES**	**NO**
Been diagnosed with a heart murmur?	**YES**	**NO**
Have diabetes?	**YES**	**NO**
Have asthma?	**YES**	**NO**
Ever been knocked unconscious?	**YES**	**NO**

Please explain if you answered "yes" for any of the questions listed to the left.

_____

_____

_____

_____

_____

_____

Date of last medical examination: _____

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MEDICAL

NEW YORK STATE PUBLIC HEALTH LAWS REQUIRE STAFF MEMBERS TO HAVE HAD THE FOLLOWING IMMUNIZATIONS:

1. Diptheria – 3 or more doses of diptheria toxoid
2. Polio – 3 or more doses of trivalent oral poliovirus vaccine (TOPV)
   German measles or 4 or more doses of inactivated poliomyelitis vaccine (IPV)
3. Measles – 1 dose of live measles vaccine administered after age of 12 months
4. Mumps – 1 dose of live mumps vaccine administered after age of 12 months
5. German Measles – 1 dose of live rubella virus vaccine administered after age 12 months
   or setiolgical evidence (blood test) of rubella antibodies

Which of the following immunizations has the staff member had?

☐ MEASLES ☐ GERMAN MEASLES ☐ HEPATITIS A ☐ HEPATITIS C

☐ CHICKEN POX ☐ MUMPS ☐ HEPATITIS B

TB MANTOUX test:

Date of last test: _____

RESULT ☐ POSITIVE ☐ NEGATIVE

TETANUS

Date of last immunization _____

I HEREBY CERTIFY THAT I HAVE RECEIVED THE INNOCULATIONS LISTED ABOVE

SIGNATURE _____ DATE _____

NAME OF FAMILY PHYSICIAN _____

ADDRESS _____ TEL _____

NAME OF FAMILY DENTIST/ORTHODONTIST _____

ADDRESS _____ TEL _____

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PARENT / GUARDIAN / ADULT STAFF AUTHORIZATION

As far as I know, the health history is complete and correct. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer over the counter/prescribed medications with doctors orders only, and seek emergency medical treatment including ordering x-rays or routine tests.

I agree the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above with the understanding that the family will be notified as soon as possible

I also understand and agree to abide by any restrictions placed on my child's/my own participation in camp activities.

This completed form may be photocopied for trips out of camp.

SIGNATURE _____

PRINTED NAME _____ DATE _____