

2012 Boulder Ridge Day Camp Medical Form for Staff

Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Section 1: Staff Portion

To be completed and signed by the staff member every year.

PERSONAL INFORMATION:

Name: First: _____ Middle: _____ Last: _____

Date of Birth: _____ Age while at camp: ____ Sex: Male Female

Home Address: _____

Emergency Contact #1: _____ Relationship to Staff Member: _____

Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

Emergency Contact #2: _____ Relationship to Staff Member: _____

Address: _____

Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____

DIETARY AND EXERCISE RESTRICTIONS: (The following restrictions apply to this individual.)

Does not eat: Red Meat Pork Dairy Products Poultry Seafood Eggs Other: _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary): _____

ALLERGIES: (Please list all known.)

Describe reaction and management of reaction:

Food Allergies: _____

Medication Allergies: _____

Other Allergies: _____

HEALTH HISTORY: (Please explain questions you answered YES to below.)

Has, or does the participant:

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 1. Had any recent injury, illness, or infectious disease? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Have any skin problems (itching, rash, acne)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have a chronic or recurring illness/condition ? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have an orthodontic appliance coming to camp? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Ever been hospitalized? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Had mononucleosis in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Ever had surgery? | <input type="checkbox"/> | <input type="checkbox"/> | 13. If female, have abnormal menstrual history? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Ever had an eating disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Ever had frequent ear infections? | <input type="checkbox"/> | <input type="checkbox"/> | 15. Ever had emotional difficulties for which professional help was sought? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Ever had seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Any recent exposure to contagious diseases? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 9. Have asthma? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If yes, please explain: _____

USE OF BUG REPELLANT:

I give permission to use bug repellent containing DEET that Ebner Camps, Inc. provides in accordance with the instructions of the attending physician and manufacturers recommendations to prevent against bites from mosquitoes and ticks.

I do not give permission to use the bug repellent that Ebner Camps, Inc. provides.

USE OF SUNSCREEN:

I give permission to use the sunscreen that Ebner Camps, Inc. provides in accordance with the instructions of the attending physician and manufacturers recommendations to prevent against sunburn.

I do not give permission to use the sunscreen that Ebner Camps, Inc. provides.

- CONTINUED ON REVERSE -

Name: (Last, First)

Section 1: Staff Portion

Name: _____

PRESCRIPTION AND DAILY NON-PRESCRIPTION MEDICATIONS:

This staff member does not take any medications routinely.

This staff member does take medications routinely. List Medications: _____

In accordance with state law, each medication, either prescription or over the counter, that is taken routinely at camp, must have a completed medication administration form signed by the physician.

NON-PRESCRIPTION MEDICATIONS:

The following medications are stocked in our infirmary and are available to be administered to your child in accordance with the standing orders of the camp physician and the dosage instructions provided on the medication packaging. Generic medications may be substituted for any of the medications listed below.

Please indicate whether or not the camp health personnel may administer these medications to you if necessary:

	Yes	No		Yes	No
Robitussin (Guaifenesin Syrup)	<input type="checkbox"/>	<input type="checkbox"/>	Advil/Motrin (Ibuprofen)	<input type="checkbox"/>	<input type="checkbox"/>
Benadryl (Diphenhydramine)	<input type="checkbox"/>	<input type="checkbox"/>	Tylenol (Acetaminophen)	<input type="checkbox"/>	<input type="checkbox"/>
Cepacol (Benzocaine/Methol) Lozenges	<input type="checkbox"/>	<input type="checkbox"/>	Immodium (Loperamide)	<input type="checkbox"/>	<input type="checkbox"/>
Chloraseptic Spray (Phenol Spray)	<input type="checkbox"/>	<input type="checkbox"/>	Hydrocortisone cream	<input type="checkbox"/>	<input type="checkbox"/>
PeptoBismol (Bismuth Subsalicylate)	<input type="checkbox"/>	<input type="checkbox"/>	Betadine/Povidine	<input type="checkbox"/>	<input type="checkbox"/>
Rolaids/Tums (Calcium Carbonate)	<input type="checkbox"/>	<input type="checkbox"/>	Bactine antiseptic spray	<input type="checkbox"/>	<input type="checkbox"/>
Midol (Acetaminophen/Pyriminamine maleate)	<input type="checkbox"/>	<input type="checkbox"/>	Visine (Tetrahydrozoline HCl)	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Rub (Camphor/Menthol cream)	<input type="checkbox"/>	<input type="checkbox"/>	Bacitracin (Triple antibiotic) ointment	<input type="checkbox"/>	<input type="checkbox"/>

IMPORTANT—THIS BOX MUST BE COMPLETE FOR ATTENDANCE!

Authorization: This health history is correct and complete as far as I know, and 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 prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I give permission for the above indicated medications to be dispensed in accordance with the camp doctor's standing orders and dosages provided on the medication packaging. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me. I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Signature of adult staff: _____

Printed name: _____ Date: _____

Section 2: Physician Portion

All staff members must have had a physical within the 3 years preceding their first day of camp. The physician may complete and sign this section or attached a signed standard school or state form provided that it includes the same information. If you have a current (within three years) physical on file from summer 2011 at Boulder Ridge, you may skip this section.

Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Other: _____

Other: _____

Please give last booster date of the following immunizations:

DPT series: _____ TD (Tetanus/Diphtheria): _____ Polio OPV (Sabin): _____

MMR: _____ Mumps: _____ Measles: _____ Rubella: _____

Influenza B: _____ Hepatitis B: _____ Varicella (chicken pox): _____

TB Mantoux test: _____ Result: Positive Negative

Height: _____ Weight: _____ BP: _____ Gross dental exam: _____

Please use a separate sheet to provide any additional information about the staff member's behavior and physical, emotional, or mental health that camp should be aware of.

Name of Staff Member's Physician: _____ Phone: () _____

Physician's Address: _____

Physician's Signature: _____	Physician's Printed Name: _____	Date Signed: _____	Date of last physical: _____
---------------------------------	------------------------------------	-----------------------	---------------------------------