

Health History Form for Camp Employee

Return this completed form to:

Your Contract Start Date: _____ End Date: _____
Title of _____
Your Position: _____

International Staff: rate your ability to speak and read English:
0 1 2 3 4 5
Low ability Good ability Fluent in English

Name: _____
First Middle Last

Gender: _____

Birthdate: _____

Permanent Address: _____
Street Address
City State/Country Zip/Code

E-mail: _____

Is this your first year as a staff member? ☐ No ☐ Yes

- **Return this form to our camp office before your arrival for work.**
- Notify the camp director if you are exposed to a communicable disease within two weeks of beginning your job.
- The camp expects that you arrive in good health and capable of performing the essential functions of your position. If you have concerns regarding this, speak with the camp director prior to arrival.
- Information on this form is available to Health Center staff on a "need to know" basis and your work supervisor(s) as deemed "need to know" only.
- Completing some portions of this form is voluntary; such areas are so marked.

If you have questions about our camp health services, please call our office to find out more.

Allergies: Check those that apply to you. Completion of this section is voluntary, yet helpful to healthcare staff.

_____ I have no known allergies.
_____ I have an allergy to this food: _____ This causes anaphylaxis? ☐ Yes ☐ No
Describe what happens if you eat this food and how the reaction is managed:

_____ I am allergic to this medication(s): _____ This causes anaphylaxis? ☐ Yes ☐ No
_____ I am allergic to these substances: _____ This causes anaphylaxis? ☐ Yes ☐ No
Describe what happens if you are exposed to these medications or substances and how the reaction is managed:

Nutrition: Our expectation is that staff set an example for campers by eating the provided meal. We work with some medically prescribed diets, such as gluten-free and lactose intolerant, but cannot cater to individual food preferences. Discuss concerns with the camp director prior to the start of camp.

_____ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.
_____ I am a vegetarian of this type:
☐ Semi-vegetarian (no pork or beef) ☐ Ovo (no meats, fish, seafood, or dairy)
☐ Pesco (no pork, beef, or chicken) ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
☐ Lacto (no meats, fish, seafood, or eggs) ☐ Vegan (no meats, seafood, eggs, or dairy)
_____ I do not eat _____ products because of religious beliefs.

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

Completion of this section is voluntary, yet helpful to healthcare staff.

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s):

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches, Migraines | <input type="checkbox"/> Sleep problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Dysmenorrhea |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Surgical history | <input type="checkbox"/> Seizure disorder: _____ |
| <input type="checkbox"/> Back pain or injury | <input type="checkbox"/> Knee or ankle weakness | <input type="checkbox"/> Other: _____ |

Your supervisor expects that staff who have chronic health concerns can perform the essential functions of the job for which they have been hired. If you have any concerns, please speak with your supervisor.

Immunization History:

Vaccines	Date Dose 1	Date Dose 2	Date Booster
DPT series (Diphtheria, Pertussis, Tetanus)	_____	_____	_____
MMR series	_____	_____	_____
Hepatitis A	_____	_____	_____
Hepatitis B	_____	_____	_____
Varicella (Chicken Pox)	_____	_____	_____
Small Pox	_____	_____	_____
Typhoid	_____	_____	_____
IPV (Polio)	_____	_____	_____

Date (month/year) of your most recent **tetanus** immunization: _____

Have you completed the immunizations that were required for school attendance? __ Yes __ No

Have you had a full course (**2 shots**) of the COVID-19 vaccination? __ Yes __ No

Medication: All medication must be locked securely unless in the immediate possession/control of the user. All medication should be originally submitted to the Health Center for administering OR kept in private staff lockers for self administering.

NOTE: You do not have to inform Health Center staff of medications EXCEPT to determine if your medication(s) may impair completion of the essential functions of your job. They may also ask about medication when you seek healthcare. Providing information about your medication is voluntary UNLESS this is the case. Please use good judgment.

Do you take medication/s that the use of non-use **could impair ability** to perform the essential job functions of the work at camp? Please list below if so. __ No

General Physical History: If you answer "Yes" to any of these questions, provide more information at the end of this section.

Completing this session is voluntary, but helpful to healthcare staff.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Have you ever been hospitalized? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Have you ever passed out during or after exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Have you ever had chest pain during or after exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Do you tire more quickly than your friends during exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Have you ever had high blood pressure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you ever had a racing heartbeat or skipped heartbeats? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you ever been knocked out or become unconscious? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Have you ever had a seizure? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Have you ever had heat or muscle cramps? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. Have you ever been dizzy or passed out in the heat? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

13. 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 ☐ Leg ☐ Neck ☐ Chest
☐ Arm, hand ☐ Ankle ☐ Back ☐ Hip ☐ Foot

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 time spent in them.

Country: _____ Dates: _____
 Country: _____ Dates: _____
 Country: _____ Dates: _____

Use the space below to explain and/or provide more detail about the General Physical Health questions to which you responded "Yes."

 # _____
 # _____

Tell us any **treatment** that is needed for yourself to maintain your ability to complete the essential functions of the job. None required OR as follows:

Do you have any **limitations** that may impact your job performance? No OR Tell us more

Have you sought prior treatment for **mental health**? No Yes

Have you been diagnosed with COVID-19 in the past? No Yes (Most recent approx. date: _____)

Is there **anything** else we should know about your health related to the job? No OR Tell us more

Name of your physician: _____ Office Phone (_____) _____

Name of your dentist/orthodontist: _____ Office Phone (_____) _____

Paying for Health Care

- There is routinely no charge for healthcare provided by the camp's Health Center staff.
- You are financially responsible for healthcare provided by all other providers.
- If you will be using personal insurance while working at camp, know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

Emergency Contact: Who do you want us to contact in an emergency?

First	Preferred	Relationship
Contact: _____	Phone: (_____) _____	to You: _____
Alternate	Preferred	Relationship
Contact: _____	Phone: (_____) _____	to You: _____

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

This health history is correct. I am mentally and physically ready to participate as an employee at the camp, capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp's Health Center staff in providing care to me and may be reviewed by my work supervisor(s) on a "need to know" basis. I give permission to the camp in case of emergency to secure proper treatment.

Signature of
 Staff Person: _____ Date: _____
 Signature of
 Parent (if needed): _____ Date: _____

Date/Time

Documentation by Health Center Staff

Initial

Screening has been conducted per camp protocol and findings noted below:

- A. Any signs/symptoms of illness or injury upon arrival? NO YES as noted below
B. Any history of exposure to communicable diseases? NO YES as noted below
C. Any additions, corrections, or clarifications to information on this form? NO YES as noted below
D. As necessary (see statement under "Medication"), medication has been reviewed with the healthcare provider?
..... NO YES as noted below
E. Any signs/symptoms of head lice? NO YES as noted below

Screening Done By: _____

EXIT NOTE: Check one of the following:

☐ Left camp this day with no reported illness or injury symptoms.

Client's exit date: _____

☐ Left camp this day with the following problem/concern: _____

Summary of nursing instructions provided: _____

Exit note completed by: _____