

STAFF MEMBER HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association,
American Academy of Pediatrics Council on School Health, &
Association of Camp Nurses



Page 1, 2 and 3 to be completed by staff member
Page 4 to be completed and signed by physician

Before 5/10 Camp Lindenmere, 6901 SW 18th Street, Suite E202
Boca Raton, FL 33433

After 5/10 Camp Lindenmere, RR1, Box 1765
Henryville, PA 18332

CAMP
USE
ONLY

STAFF MEMBER

Staff Member Name _____

Staff Members Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody to be contacted in case of illness or injury:

Name: _____ Relationship _____ Preferred Phones: (_____) _____ (_____) _____
Email: _____

Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name: _____ Relationship _____ Preferred Phones: (_____) _____ (_____) _____
Email: _____

Additional contact in event parent(s)/guardian(s) can not be reached:

Name(s): _____ Relationship _____ Preferred Phones: (_____) _____ (_____) _____

Allergies: No known allergies. Staff member is allergic to: Food Medicine The environment (insect stings, hay fever, etc.) Other
(Please describe below what the allergy is and the reaction seen.)

Restrictions: I have reviewed the program and activities of the camp and feel that I can participate without restrictions.
 I have reviewed the program and activities of the camp and feel that I can participate with the following restrictions or adaptations.
(Please describe below)

Medical Insurance Information:

The staff member is covered by family medical/hospital insurance Yes No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Phone Number (_____) _____

Parent/Guardian Authorization for Health Care: (only for staff member under the age of 18)

This health history is correct and accurately reflects the health status of the camper to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Custodial Parent/Guardian _____ Date: _____ Relationship to Staff Member: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

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BUNK

SESSION

STAFF MEMBER HEALTH HISTORY

Staff Member: _____
 First Middle Last

Birth Date: _____
 Month/Day/Year

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Immunization History: Provide the month and year for each immunization. Starred (★) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

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)						
Mumps, measles, rubella ★ (MMR)						
Polio ★ (IPV)						
Haemophilus influenzae type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox)	<input type="checkbox"/> Had chicken pox Date: _____					
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test Date: _____ Negative Positive

If you have not been fully immunized, please sign the following statement. I understand and accept the risks from not being fully immunized.

Signature _____

- Medication:** Staff member will not take any daily medications while attending camp.
 Staff member will take the following daily medication(s) while at camp:

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies. **Please review camp instructions about required packaging/containers. Many states require original pharmacy containers with labels which show the camper's name and how the medication should be given. Provide enough of each medication to last the entire time the camper will be at camp.**

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Cross out those you should not be given.**

- | | |
|---|---|
| Acetaminophen (Tylenol) | Ibuprofen (Advil, Motrin) |
| Phenylephrine decongestant (Sudafed PE) | Pseudoephedrine decongestant (Sudafed) |
| Antihistamine/allergy medicine | Guaifenesin cough syrup (Robitussin) |
| Diphenhydramine antihistamine/allergy medicine (Benadryl) | Dextromethorphan cough syrup (Robitussin DM) |
| Sore throat spray | Generic cough drops |
| Lice shampoo or cream (Nix or Elimite) | Antibiotic cream |
| Calamine lotion | Aloe |
| Laxatives for constipation (Ex-Lax) | Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol) |

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Staff Member: _____
First Middle Last

General Health History: Check "Yes" or "No" for each statement. Explain "Yes" answers below.

Has/does the camper:

- | | | | | | |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Ever been hospitalized? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 11. Had fainting or dizziness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Ever had surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. Passed out/had chest pain during exercise? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Have recurrent/chronic illnesses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Had mononucleosis ("mono") during the past 12 months?... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Had a recent infectious disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 14. If female, have problems with periods/menstruation?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Had a recent injury? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 15. Have problems with falling asleep/sleepwalking? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Had asthma/wheezing/shortness of breath?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 16. Ever had back/joint problems?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 17. Have a history of bedwetting?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Had seizures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 18. Have problems with diarrhea/constipation?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Had headaches? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 19. Have any skin problems?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Wear glasses, contacts, or protective eyewear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 20. Traveled outside the country in the past 9 months?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain "Yes" answers in the space below, noting the number of the questions. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement.

1. Have you ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)?
 2. Have you ever been treated for emotional or behavioral difficulties or an eating disorder?
 3. During the past 12 months, seen a professional to address mental/emotional health concerns?.....
 4. Have you ever had a significant life event that continues to affect your life?
- (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of primary doctor(s): _____ Phone: (_____) _____
Name of dentist(s): _____ Phone: (_____) _____
Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about your health that you think important or that may affect the camper's ability to fully participate in the camp program. **Attach additional information**

**STAFF HEALTH-CARE RECOMMENDATIONS
by LICENSED MEDICAL PERSONNEL**

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The following non-prescription medications are commonly stocked in camp Health Centers and are used on an as needed basis to manage illness and injury. **Medical personnel: Cross out those items the camper should not be given.**

- Acetaminophen (Tylenol)
- Ibuprofen (Advil, Motrin)
- Phenylephrine (Sudafed PE)
- Pseudoephedrine (Sudafed)
- Chlorpheniramine maleate
- Guaifenesin
- Dextromethorphan
- Diphenhydramine (Benadryl)
- Generic cough drops
- Chloraseptic (Sore throat spray)
- Lice shampoo or scabies cream (Nix or Elimite)
- Calamine lotion
- Bismuth subsalicylate (Pepto-Bismol)
- Laxatives for constipation (Ex-Lax)
- Hydrocortisone 1% cream
- Topical antibiotic cream
- Calamine lotion
- Aloe

STAFF MEMBER _____

DATE OF BIRTH _____

Medical Personnel: Please review the STAFF HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: Yes No (If "No," date of last physical: _____)
Month/Day/Year

ACA accreditation standards specify physical exam within last 24 months.

Weight: _____ lbs Height: _____ ft _____ in Blood Pressure _____ / _____

Allergies: No Known Allergies

To foods (*list*):

To medications: (*list*):

To the environment (*insect stings, hay fever, etc.— list*):

Other allergies: (*list*):

Describe previous reactions:

Diet, Nutrition: Eats a regular diet. Has a medically prescribed meal plan or dietary restrictions: (*describe below*)

The staff member is undergoing treatment at this time for the following conditions: (*describe below*) None.

Medication: No daily medications. Will take the following prescribed medication(s) while at camp: (*name, dose, frequency—describe below*)

Other treatments/therapies to be continued at camp: (*describe below*) None needed.

Do you feel that the staff member will require limitations or restrictions to activity while at camp? No Yes

If you answered "Yes" to the question above, what do you recommend? (describe below—attach additional information if needed)

**"I have reviewed the HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the staff member
It is my opinion that the staff member is physically and emotionally fit to participate in an active camp program (except as
noted above.)**

Name of licensed provider (please print): _____ Signature: _____ Title: _____

Office Address _____
Street City State Zip Code

Telephone: (_____) _____ Date: _____