Staff: _____ **Address:** _____ **DOB:** _____
Last Name **First Name**

Page 1 to be completed by Health Care Provider

STAFF MEDICAL FORM (Physician)

IMMUNIZATION & HEALTH HISTORY

All immunization information, including dates, for the staff member must be submitted in order for staff member to be admitted to camp. Staff members must have current immunizations or proof of a MEDICAL exemption in order to attend camp.

VACCINE	Mo./Yr.	Mo./Yr.	Mo./Yr.	Mo./Yr.
DTaP/Tdap (tetanus/diphtheria)				
Tetanus				
Polio				
MMR				
Or Measles				
Or Mumps				
Or Rubella				
Haemophilus Influenza B				
Hepatitis B				
Varicella (Chicken Pox)				
Meningococcal conjugate vaccine (MenACWY) 7-12 grades only				

Check the following disease staff member had:

- ☐ Measles
- ☐ Chicken Pox
- ☐ German Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Tuberculosis
- ☐ Lyme Disease
- ☐ West Nile Virus
- ☐ Meningitis
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C

Health History

1. Last physical exam date: _____
(*The staff member must have a completed physical exam no more than 2 years before the camp session for which they are attending.*)
2. Are there any restrictions for this staff member while attending camp?
_____
3. Is there any additional health information or special instructions for this staff member?
_____

MEDICATIONS TO BE TAKEN AT CAMP (to be completed by physician)

Please list all medications (including over-the-counter or nonprescription drugs) taken routinely by staff member.

□ This staff member takes no medication on a routine basis.

□ This staff member takes medication as follows:

MEDICATION*	REASON FOR TAKING	DOSAGE	SCHEDULE TIME
			□ Breakfast □ Lunch □ Dinner □ Bedtime
			□ Breakfast □ Lunch □ Dinner □ Bedtime
			□ Breakfast □ Lunch □ Dinner □ Bedtime
			□ Breakfast □ Lunch □ Dinner □ Bedtime
			□ Breakfast □ Lunch □ Dinner □ Bedtime

Attach additional pages for more medication requirements

NON-PRESCRIPTION MEDICATION STANDING ORDERS (to be completed by physician)

Upon documented approval by staff member's physician, the following non-prescription medications are available in the camp's infirmary and will be administered at the discretion of the Camp Health Director.

Non-Prescription Medication	Tylenol or generic	Advil or generic	Neosporin or generic	Benadryl or generic	Calamine lotion or generic	Tums or generic	Imodium or generic	Robitussin or generic
Permission to Administer	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Dosage and Schedule								

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.

Physician's Signature: _____ **Date:** _____

Physician's Address and Phone Number: _____

Staff: _____ **Address:** _____ **DOB:** _____
Last Name **First Name**

STAFF MEDICAL FORM

Page 2 to be completed by Staff member

Please complete all information clearly. This information is important in the event of an accident at camp. You may not receive necessary and timely treatment without it. **NOTE:** Bring sufficient supply of medication to last the entire time at camp. Keep the medication in the original packaging/bottle which identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Contact Information:

Parent/Guardian Name: _____
Primary Phone #: _____
Secondary Phone #: _____

Emergency Contact Name: _____
Primary Phone #: _____
Secondary Phone #: _____

Medical Care Providers:

Physician Name: _____
Phone #: _____
Address: _____

Dentist/Orthodontist: _____
Phone #: _____
Address: _____

Insurance Information: (You will *not* be admitted to camp without this information)

Is the staff member covered by family medical/hospital insurance? □ YES □ NO
If so, indicate carrier or plan name: _____ Group No. _____
Name of Insured _____ Relationship to Camper _____
Policy holder Insurance ID No. _____ Medicaid Number _____

Health History

The following information must be filled out by the staff member. The intent is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any change to this form should be provided to camp health personnel upon staff member's arrival in camp. Provide complete information so that the camp can be aware of your needs. This form is confidential, observed only by camp health staff, medical staff and NYS Department of Health.

General Questions: Explain "Yes" answers below or on a separate piece of paper attached to this form.

The participant has/has had:

Y	N		Y	N		Y	N	
□	□	a recent injury, illness or infectious disease	□	□	back problems	□	□	problems with joints (e.g. knees, ankles)
□	□	a chronic or recurring illness/condition	□	□	been hospitalized	□	□	any skin problems (e.g. itching, rash, acne)
□	□	an orthodontic appliance	□	□	surgery	□	□	frequent headaches
□	□	glasses, contacts, or protective eyewear	□	□	diabetes	□	□	a head injury
□	□	problems with diarrhea/constipation	□	□	seizures	□	□	frequent ear infections
□	□	problems with sleepwalking	□	□	eating disorder	□	□	a history of bedwetting
□	□	dizziness or fainting during or after exercise	□	□	a diagnosed heart murmur	□	□	chest pain during or after exercise
□	□	if female: abnormal menstrual cycle	□	□	high blood pressure	□	□	emotional difficulties for which professional help was sought

Allergies: Please describe reaction and management of all known allergies:

Medication Allergies: _____Food Allergies: _____
Other Allergies: _____

Please provide additional information about the staff member's behavioral, physical, emotional or mental health about which the camp should be aware.

_____

Identify any medication the staff member takes during the school year that the staff member does not/may not take during the summer: _____

Permission to Provide Necessary Treatment of Emergency Care (Please Read Carefully):

Parent/Guardian Authorizations: 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 agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child. In the event 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. This completed form may be photocopied for trips out of camp. **Note: Camp insurance provides secondary coverage only. The parent's insurance carrier will be billed first for all accidents and illnesses at camp.

I understand that I am required to submit this STAFF MEMBER MEDICAL FORM along with staff member's IMMUNIZATION RECORDS in order for admittance to camp.

Signature & Date (Parent/Guardian if minor): _____

(You will *not* be admitted to camp without this signature) **Name Printed** **Signature** **Date**