Camp Burt R Shurly — **2019 Seasonal Staff Health Form**

Name ______________________________ Birth date ____________ Age ________ Male / Female
last first middle — month / day / year — circle one

Home Address ____
Street Address City State Zip

Parent/guardian ______________________________ Phone ____________
Home Address ____
(If different from above) Street Address City State Zip

Second parent/guardian or emergency contact ______________________________
Address ______________________________ Phone ____________
Street address City State Zip

If parent is not available in an emergency, notify ______________________________
Relationship ____________ Phone numbers (   ) ____________ (   ) ____________

Medical Insurance Information:
Is the participant covered by family medical/hospital insurance? ☐Yes ☐No
Insurance Company ______________________ Policy # ______________________
Name of Insured ______________________ Insurance Company Phone ____________

Allergies: ☐ No known allergies. ☐ This camper is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe what the camper is allergic to 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.)***

Medications: ☐ I will NOT take any daily medications while at camp.
☐ I 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 and natural remedies. ***The Michigan Department of Human Services rules require that original pharmacy containers with labels which show the patient's name and how the medication should be dispensed. Will you be taking any medications that might impair your ability to perform the essential functions of your job?*** ☐ YES ☐ NO

Name of medication	Date started	Reason for taking it	When it is given	Amount or dose given	How it is given
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		
			☐ Breakfast ☐ Lunch ☐ Dinner ☐ Bedtime ☐ Other time:		

Physician: ______________________________ Phone: ____________
Dentist: ______________________________ Phone: ____________

This health history is correct and accurately reflects the health status of the staff member named herein. The staff meber named herein has permission (or agrees) to participate in all necessary activities except as noted on this form. Signator gives permission to the physician selected by Camp Burt Shurly to order x-rays, routine tests, and treatment related to both routine health care and emergency care. If emergency contact cannot be reached in an emergency, I give my permission for the physician to hospitlize, secure proper treatment for, and order injection, anethesthsia, or surgery. I understand the information on this form will be shared on a "need to know" basis with other camp staff. I give permission to photocopy and/or electronically store this form. In addition, the camp has permission to obtain a copy of the staff member's health record from providers used and these providers may talk with the program's staff about my / my child's health status.

Signature of
Staff Member: ______________________________ Date: ____________

Signature of custodial
Parent/Guardian (if minor) ______________________________ Relationship to Minor Staff: ____________

Continued on back ➔

 Name: ______________________________

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

Has/does the staff member:

	Yes	No
1. Had any recent illness or infectious disease?	☐	☐
2. Have a chronic or recurring illness?………..	☐	☐
3. Have problems with falling asleep / sleepwalking?	☐	☐
4. Had mononucleosis (mono) in the past 12 months?	☐	☐
5. If female, have an abnormal menstrual history?	☐	☐
6. Passed out / had chest pain during exercise?	☐	☐
7. Have any dietary restrictions?	☐	☐
8. Wear glasses, contacts, or protective eye wear?	☐	☐
9. Ever had frequent ear infections?	☐	☐
10. Had fainting or dizziness?	☐	☐
11. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
12. Have any skin problems (e.g. itching, rash, acne)?	☐	☐
13. Ever been diagnosed with a heart murmur?	☐	☐
14. Had problems with diarrhea/constipation?	☐	☐
15. Have asthma and/or shortness of breath?	☐	☐
16. Traveled out of the country in the past 9 months?	☐	☐
17. Significant event that is affecting you? (abuse, death in family, adoption, foster care, new sibling, etc.)	☐	☐
18. Had a recent injury?	☐	☐
19. Ever had dental problems?	☐	☐
20. Have diabetes?	☐	☐
21. Have a history of bedwetting?	☐	☐
22. Ever been hospitalized?	☐	☐
23. Ever had surgery?	☐	☐
24. Ever had a head injury?	☐	☐
25. Ever had seizures?	☐	☐
26. Ever had high blood pressure?	☐	☐
27. Ever had back problems?	☐	☐
28. Have frequent headaches?	☐	☐
29. Ever had an eating disorder?	☐	☐
30. Ever been knocked unconscious?	☐	☐
31. Treated for ADD or ADHD?	☐	☐

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. List also any other current medical or physical conditions requiring medication, treatment or special restrictions.

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
Diptheria, tetanus, pertussis * (DTaP) or (TdaP)						
Tetanus booster * (dT) or (TdaP)						
Mumps, measles, rubella * (MMR)						
Polio * (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) / or Had chicken pox—date? ____						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative	☐ Positive

If the seasonal staff member has not been fully immunized, or if you cannot fully complete the Immunization Chart above, please sign the following statement: I understand and accept the risks of not being fully immunized.

Signature of Staff Member or Parent/Guardian (if a minor): ______________________ Date: ____________ Relationship to staff: ________

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 the items that should NOT be given.***

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

List here any other medications that the staff member should not take?