CAMP BERGER HEALTH FORM for STAFF 2012 Update

DATE(S) ATTENDING _____

Staff: Please give complete information below so the camp is aware of your needs and has the information necessary for appropriate care. Please mail a copy of this form before your first week at camp, bring a back-up copy with you upon check in and maintain a copy for your own records. If there are changes after you send us the form, please notify the nurse upon arrival at camp.

Note: Please return this form directly to: Camp Berger, 134 Wahnee Road P.O. Box 181 Winchester Center, Ct. 06094

Last Name _____ First _____ M.I.___ Nickname _____
Birth date: _____/_____/_____ M F
Custodial parent/guardian _____ HomePhone:(_____)_____
Home address _____ City, State, Zip _____
Work Phone (_____)_____Cell Phone(_____)_____
Second parent/guardian _____Home Phone: (_____)_____
Home address _____ City, State, Zip_____
Work Phone (_____)_____Cell Phone(_____)_____
If under 18, please indicate who the staff member lives with_____

If neither of the above are available in an emergency, please notify:

Alternate contact #1:
Name_____Relationship:_____
Home Phone: (_____)_____Cell Phone: (_____)_____Work Phone:(_____)_____

Alternate contact #2: Name_____ Relationship: _____
Home Phone: (_____)_____Cell Phone: (_____)_____Work Phone:(_____)_____

Name of Family Physician:_____Phone:
(_____)_____
Name ofDentist/Orthodontist:_____Phone:(_____)_____

Do you have medical/hospital insurance? _____ If yes, Policy Holders Name_____
Employer through which insurance isobtained:_____
Carrier: _____Policy or Group#_____

Do you have prescription drug insurance? _____ If yes, PolicyHolder'sName:_____
Carrier:_____ Policy or Group #_____

Please attach a copy of both sides of your insurance card. Without this attachment, treatment can be delayed.

IMPORTANT – MUST BE COMPLETED FOR ATTENDANCE

Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by the examining physician and/or I. I understand there are some inherent risks in activities at camp and accidents sometimes occur. I assume the risk for any and all injuries. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for my health and in the event I am unconscious and it is an emergency, I hereby give permission to anesthesia and/or surgery. I agree to remain at camp for the duration of my contract unless necessary to withdraw due to illness as defined by the camp physician. I give permission for Camp Camp to use my likeness in photos or videos for promotional literature.

Staff Member Signature _____ Date_____
Print Name _____Witness Signature_____

Parent/Guardian Signature (if staff member under 18)_____

STAFF NAME _____DATES ATTENDING_____

STAFF MEDICAL HISTORY – TO BE FILLED OUT BY PARENT (if under 18) or SELF

Health History: (check – giving approximate dates).

_____Frequent ear infections
_____Heart Defect/Disease
_____Convulsions
_____Diabetes (onset)
_____Bleeding/Clotting Disorders
_____Epilepsy (onset)
_____Tonsillitis

Other diseases or detail of the above:_____

Allergies

_____Hay Fever
_____Poison Ivy etc.
_____Insect Stings
_____Penicillin
_____Other Drugs
_____Peanuts
_____Other Foods

Diseases

_____Rheumatic Fever
_____Chicken Pox
_____Measles
_____German Measles
_____Mumps
_____Asthma
_____Strep Throat
_____Mononucleosis

Operations or serious injuries(dates):_____

Chronic or recurring illness or SpecialNeeds:_____

(For girls) Is your menstrual history normal?_____ If No, what should the nurse be aware of?_____

Special considerations or suggestions:_____

Camp Berger's Infirmary is stocked with some over-the-counter non-prescription medications. Are there any over-the- counter, non-prescription medications or ointments that SHOULD NOT be given to staff member?

MEDICAL EXAMINATION – TO BE FILLED OUT BY LICENSED PHYSICIAN

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining ability to engage in strenuous activities. Laboratory tests done at discretion of physician.

CODE: V = Satisfactory; X = Not satisfactory (explain); O = Not examined

Height:_____ Weight:_____ BP:_____ Resting Pulse:_____

____Eyes
____Glasses
____Ears
____Nose
____Throat
____Heart

_____Lungs
_____Abdomen
_____Hernia
_____Extremites
_____Posture(spine)
_____Skin

Allergies (please specify) _____

_____

_____

General Appraisal _____

_____

_____

Date of last Tetanus_____

Immunizations are up-to-date: _____Yes _____No If No, Reason: _____

Recommendations and restrictions while at camp:
Swimming/diving_____Strenuous Activity:_____

Other: _____Special Diet:_____

Current medications (list name, dosage and time schedule): All medications must be in a correctly labeled original container and given to the nurse at check-in time. NO MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) WILL BE ALLOWED IN THE CABENT/LODGE UNLESS AUTHORIZED BY THE NURSE.

_____
_____
_____

I have examined this person herein described and have reviewed the health history. It is my opinion that this person is physically able to engage in camp activities, except as noted.

Doctor signs here:_____ M.D. Date_____

Address:_____

Phone: (_____)_____ Fax: (_____)_____