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 Low ability 1 2 Good ability 3 4 5 Fluent in English

Name: _____
First Middle Last

☐ Male
Sex: ☐ Female 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 at least four weeks prior to your arrival. People hired within four weeks of their start date should not send this form; bring it with you and give it to the Health Center staff at camp.*
- *Notify the camp director if you are exposed to a communicable disease within three 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 and your work supervisor(s) as necessary.*
- *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.

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)
- ☐ Pesco (no pork, beef, or chicken)
- ☐ Lacto (no meats, fish, seafood, or eggs)
- ☐ Ovo (no meats, fish, seafood, or dairy)
- ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
- ☐ Vegan (no meats, seafood, eggs, or dairy)

_____ I do not eat _____ products because of religious beliefs.

Chronic Concerns: *Check all that pertain 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):

☐ Asthma ☐ Headaches, Migraines ☐ Sleep problem

☐ Diabetes ☐ Difficulty breathing ☐

Dysmenorrhea

☐ Fainting ☐ Surgical history ☐ Seizure disorder: _____

☐ Back pain or injury ☐ Knee or ankle weakness ☐ Other: _____

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

Immunization History:

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

Have you completed the immunizations that were required for school attendance? ..... ☐ 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.*

NOTE: Health Center staff will ask about your medication(s) to determine if the use (or non-use) of such medication will impair completion of the essential functions of your job. They may also ask about medication when you seek healthcare. Providing additional information about your medication is voluntary.

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

_____ _____

_____ _____

_____ _____

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

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

Paying for Health Care

- There is usually 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 Contact: _____ Preferred Phone: (_____)_____ Relationship to You: _____

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

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

This health history is correct. I am 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).

Signature of Staff Person: _____ *Date:* _____

Signature of Parent (if needed): _____ *Date :* _____

Staff Member STOP Here.

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: _____

MEDICAL RECOMMENDATION for CAMP EMPLOYEE

Return this completed form to:

[Insert Camp Name & Address]

[Insert phone number to use should the MD/NP have questions.]

These medications are stocked in our camp's Health Center and will be used to manage illness and/or injury of this employee.
CROSS OUT those that are contraindicated for this person.

[Insert list of medications stocked in the Health Center such as those that follow]
Acetaminophen
Aloe
Bismuth Chew Tab
Calamine Lotion
Chlorpheniramine maleate
Diphenhydramine
Epinephrine
Guaifenesin DM
Hydrocortisone Cream
Ibuprofen
Kaopectate
Cough Drops
Ivy Dry
Nix
Tolnaftate
Tropical Antibiotic Cream
Pseudoephedrine

Authorization

By signing this form, you are telling us that, in your opinion, this person is both physically and emotionally ready to participate as an employee at our camp, except as noted in your comments.

Your Signature: _____

Date: _____

To Physicians and their Staff:
This person is an employee at [insert camp name & location]. The job includes physical activity such as [insert most rigorous job duty] and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the employee's supervisor use the information on this form to guide their interface with the employee. The employee can provide their job's description and list of essential functions to you. If you question the person's suitability for their job, please talk with him or her about your concerns and develop a plan to address that concern. You may also speak to one of our camp professionals by calling [insert phone number]. Thank you!

Name of Employee: _____ Date of Birth: _____

1. Does this person have a chronic health problem(s) that may prevent them from fulfilling the essential functions of their job? ..... ☐ No
   ☐ Asthma ☐ Allergies ☐ Diabetes
   ☐ Other _____

2. To what is this person allergic? ..... ☐ No Allergies
   a. _____ ☐ Causes anaphylaxis
   b. _____ ☐ Causes anaphylaxis
   c. _____ ☐ Causes anaphylaxis
   Note: Our expectation is that the employee will have an EpiPen® and know how to use it if anaphylaxis is a concern.

3. Does this individual take any medication(s) that the use of (or non-use) could impair his/her ability to perform the essential functions of his/her job? If so, please list below: ..... ☐ No medication that impacts job function.
   a. _____
   b. _____

4. Describe the treatment(s) needed by this person to maintain their ability to complete the essential functions of their job.
   ☐ None needed.
   ☐ Treatment as follows: _____

5. Describe any significant findings about this person and/or describe any limitations that may impact the employee's job performance.
   ☐ No significant findings.
   ☐ Findings as follows: _____

6. What else should the employer know about this employee's health insofar as its impact upon job performance?
   ☐ No other information needed.
   ☐ Information as follows: