Post Office Box 70159
Staten Island, New York 10307

STAFF HEALTH HISTORY FORM 2015

The information on this form is not part of the staff acceptance process, but is gathered to assist us in identifying appropriate care. This form, except for the "Health Care Physical Exam & Recommendations by Licensed Medical Personnel," must be filled out by hired Staten Island Day Camp Staff Member.

Gender: ( ) Male ( ) Female Social Security #:_____
Name:_____
Birthdate:_____ Age:_____ Email:_____
Home Address:_____
Home Phone:_____ Cell:_____
Phone:_____

Parent/Guardian:
Mr./Mrs./Ms._____
Adress:_____
Home Phone:_____ Cell:_____
Phone:_____
Email:_____

*****PLEASE ENLARGE & COPY BOTH SIDES OF YOUR INSURANCE CARD AND ATTACH TO THESE FORMS**

Are you covered by family medical/hospital insurance? ( )Yes ( )No
Name of Insurance:_____
Name of Policy Holder:_____
Policy Holder Employer:_____
Policy Holder date of birth:_____
Carrier Address:_____
Phone:_____
Group #:_____
Certificate #:_____

This health history is correct and complete as far as I know. The staff member herein described has permission to engage in all camp activities. I hereby give permission to the medical personnel, selected by the camp director, to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to release any records necessary for insurance purposes. I give permission to the camp to provide or arrange necessary related transportation for me. Medical personnel, selected by the camp director, has permission to secure and administer treatment, including hospitalization, for the staff member named above. I give permission to medical personnel, selected by the camp director, to share information with the staff member's private healthcare provider. This completed form may be shared with camp staff, as needed.

Signature of staff member:_____ Date:_____

The following information must be filled in by the staff member. The intent of this information is to provide camp health care personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to camp health personnel upon participant's arrival at camp. Provide complete information so that the camp can be aware of your needs.

ALLERGIES List all known:_____
Describe reaction and management of the reaction:_____
Medication allergies (list):_____
Food allergies (list):_____
Other allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.
_____ _____ _____ _____

MEDICATIONS
Please list all medications (including non-prescription) which will be taken routinely at camp.

_____ _____ _____ _____

Please list all healthcare providers currently treating staff member.

Name of physician:_____
Phone:_____
Address:_____
Name of dentist/orthodontist:_____
Phone:_____
Address:_____
Names of additional healthcare providers (e.g. psychiatrist, homeopath, allergist, dermatologist)
Name:_____
Specialty:_____
Phone:_____
Address:_____
( )Yes ( ) No This staff member takes NO medications on a routine basis.
( ) This staff member takes medications during the school year that will not be taken during the summer:
( ) This staff member will take the following medications at camp:
Med #1:_____
Dosage:_____
Specific times taken each day:_____
Reason for taking:_____
Med #2:_____
Dosage:_____
Specific times taken each day:_____

General Questions (Explain "Yes" answers below.)
Has/does the staff member:

	Yes	No
1 Have a chronic or recurring illness/condition?	( )	( )
2 Ever been hospitalized?	( )	( )
3 Ever had surgery?	( )	( )
4 Have frequent headaches?	( )	( )
5 Ever had a head injury?	( )	( )
6 Ever had frequent ear infections?	( )	( )
7 Ever had seizures?	( )	( )
8 Ever had chest pain during or after exercise?	( )	( )
9 Ever had high blood pressure?	( )	( )
10. Ever had problems with joints?	( )	( )

11. Have any skin problems (e.g., itching, rash, acne)? .... ( ) ( )
12. Had mononucleosis in the past 12 months?..... ( ) ( )
13. Have problems with sleepwalking?..... ( ) ( )
14. Have an eating disorder?..... ( ) ( )

Please explain "Yes" answers, noting the number of the question.

_____
_____
_____

Use this space to provide any additional information about the staff member's behavior and physical, emotional, or mental health about which the camp should be aware.

Health Care Physical Exam & Recommendations by Licensed Medical Personnel

Staten Island Day Camp Inc. requires exams within 3 months prior to camp - a valid exam must be after March 1, 2015.

SCREENING RECORD (*For* Camp *Use Only*)
Updates/additions to health history noted ( )Yes ( )No
I have examined the above staff member on *(MM/DD/YY)*_____
Signature of Licensed Medical Personnel:_____

BP:_____ Weight_____ Height_____
In my opinion, the above participant ( ) is ( ) is not able to participate in an active camp program.
The staff member is under the care of a physician or other healthcare provider for the following conditions:
_____ _____ _____ _____
Are there any medications that are taken during the year that will not be taken while at camp?
Current treatment at the time of this report includes: _____ _____

Restrictions at Camp

Additional information for health care staff at the camp (please include any issues that might impact the staff member's camp
experience):_____
_____

I authorize my patient_____(name) to participate in all camp activities.
Signature of Licensed Medical Personnel:_____ Date:_____

Which of the following has the participant had?
( ) Measles ( ) Chicken Pox ( ) German Measles ( ) Mumps ( ) Hepatitis A ( ) Hepatitis B ( ) Hepatitis C( )
TB Mantoux Test:_____ Date of last test:_____ Result: ( )Pos ( )Neg

Please give all dates of immunization for:
DTP Mo/Yr_____
TD (tetanus/diphtheria) Mo/Yr_____
TdaP Mo/Yr_____
Polio Mo/Yr_____
MMR Mo/Yr_____
Measles Mo/Yr_____
Mumps Mo/Yr_____
Rubella Mo/Yr_____
Haemophilus influenza B Mo/Yr_____
Hepatitis B Mo/Yr_____
Varicella (chicken pox) Mo/Yr_____
Menactra Mo/Yr_____