# Camp Staff Health History

Influenced by the American Camping Association/Developed and Approved by Camp MiVoden
Information on this form is not part of the staff acceptance process, but is gathered to assist us in identifying appropriate care.
(This side to be filled in by parents/guardian of minors or by adult staff members themselves)

Name: Birthdate: Sex: Age:
Last First Middle

Home Address: Phone:
Street & Number City State Zip

Parent or Guardian (or spouse):
Last First

Parent or Guardian Address: Phone:
Street & Number City State Zip

Business Address: Phone:
Street & Number City State Zip

If not available in an emergency, notify:
Name

Address: Phone:
Street & Number City State Zip

**Health History**
(Check, give approximate dates)

____ Frequent ear infections
____ Heart defect/disease
____ Convulsions
____ Diabetes
____ Bleeding/clotting disorders
____ Hypertension
____ Mononucleosis
____ Asthma

*Diseases*

____ Chicken Pox
____ Measles
____ German Measles
____ Mumps

*Allergies (dates not needed)*

____ No drug allergies
____ No known allergies
____ Hay Fever
____ Ivy Poisoning, etc.
____ Insect Stings
____ Other (Specify)

Operations or serious injuries (dates):

Medical conditions or chronic recurring illnesses:

Dietary restrictions:

Name of dentist/orthodontist: Phone:

Name of family physician: Phone:

Do you carry family medical/hospital insurance? __ Yes __ No

If so, indicate: Carrier: Policy or Group #

Carrier Address:
Street & Number City State Zip

Comments:

For Female:
Is menstrual history normal? (comments):

**Important: The following must be signed for attendance**

This health history is correct so far as I know and the person herein described has permission to engage in all prescribed camp activities except as noted. Authorization for treatment: I hereby give to the medical personnel selected by the camp director to five treatment; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature of adult staff/parent/guardian Relationship:

Witness: Date:

I also understand and agree to abide with the restrictions placed on my camp activities.

Signature of minor or adult staff: Date:

| Vaccines | Year of Basic Immunization | Year of Last Booster |
|---|---|---|
| Diphtheria<br>Pertussis (Whooping cough) DPT<br>Tetanus (IMPORTANT) | 1<br>2<br>3 | 1<br>2 |
| Tetanus<br>Diphtheria TD | | |
| Tetanus | | |
| Oral Polio (Sabin) TOPV | | |
| Injectable Polio (Salk) | | |
| Measles (hard measles, red measles, Rubeola) | | |
| Mumps | | |
| Rubella (German measles, 3-day measles) | | |
| Other | | |
| Tuberculin test given (most recent) | | |
| Haemophilus influenza b (HIB) | | |
| Hepatitis B | | |

**Comments:**________________________________________