

# 2012 STAFF HEALTH FORM

## Holston Conference Camp and Retreat Ministries

Year \_\_\_\_\_

Session \_\_\_\_\_

FOR OFFICIAL USE: Staff Name \_\_\_\_\_

**Staff Name (Print)** \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_ Grade in fall: \_\_\_\_\_

Parent/Guardian/Spouse: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cellular Phone: (\_\_\_\_) \_\_\_\_\_

**In an emergency situation, use these contacts as necessary:**

Second Parent/Guardian: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
 Work Phone: (\_\_\_\_) \_\_\_\_\_ Cellular Phone: (\_\_\_\_) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_  
 Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Staff's Physician: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Family Insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Subscriber's Name: \_\_\_\_\_ SS# \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_

Pre-Authorization Phone # if required (\_\_\_\_) \_\_\_\_\_

**Authorization – Must be signed.**

In signing this authorization, I acknowledge that I have read the event description and am aware that the activities associated with this event entail certain inherent risks including damage to property, personal injury, and even death. In consideration for being permitted to participate in this event, I agree to assume all such risks and hereby release and discharge Holston Conference Camp and Retreat Ministries, Inc., it's affiliated camps, officers, sponsors, trustees, employees, agents and other aids and/or volunteers from any and all liability for any and all damage, loss, injury, or death of every kind and nature whatsoever which in any way arises out of my participation in this event.

I hereby give permission to the camp to provide routine health care, administer prescription drugs, and seek emergency medical treatment including ordering X-rays and/or routine tests. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment, and to order injection and/or anesthesia and/or surgery for me/or my child as named above.

The health history on pages 2 and 3 is correct so far as I know.

The person herein described has permission to engage in all prescribed camp activities except as noted.

I give permission for me/my child to be transported in a private vehicle if necessary.

I give permission for photographs taken of me/or my child to be used for camp publicity, printed or electronic.

**Signature of parent/guardian or adult staff** \_\_\_\_\_

This form may be photocopied for use out of camp. **Date** \_\_\_\_\_

Staff Name (Print) \_\_\_\_\_

**STAFF HEALTH HISTORY AND PROFILE**

**General Health Status**

	Yes	No		Yes	No
Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had problems with ankle or knee joints?	<input type="checkbox"/>	<input type="checkbox"/>
Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	Have any skin problems (itching, rash, etc)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have asthma? Does camper carry an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>
Have had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	Had mononucleosis in last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	Have history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
Ever fainted?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	Wear Glasses, contacts or protective eye wear?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had chest pains during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have an orthodontic appliance at camp?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	Ever had emotional difficulties requiring prof. help?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Ever been diagnosed with ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>	If female, has started menstruating?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain "yes" answers: \_\_\_\_\_

List other Physical, Emotional, Behavioral, or Mental Health Concerns \_\_\_\_\_

**Has staff ever had an allergic reaction to: (describe what sets off reaction and its severity)**

Foods: (Please list) \_\_\_\_\_

Drugs: (Please list) \_\_\_\_\_

Insect Stings: \_\_\_\_\_ Has staff ever been stung by a bee? \_\_\_\_\_ Does staff carry an Epi-pen? \_\_\_\_\_

Ivy Poisoning: \_\_\_\_\_ Other: \_\_\_\_\_

**Immunization Record** (complete or attach a copy of Vaccine Administration Records)

Which of the following has the participant had?	Please give all dates of immunization for:							
	Vaccine:	Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
<input type="checkbox"/> Measles DTP	TD (tetanus/diphtheria)		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Chicken pox	Tetanus		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> German Measles	Polio		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Mumps	MMR		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis A	or Measles		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis B	or Mumps		_____	_____	_____	_____	_____	_____
<input type="checkbox"/> Hepatitis C	or Rubella		_____	_____	_____	_____	_____	_____
TB Mantoux Test	Haemophilus influenza B		_____	_____	_____	_____	_____	_____
Date of last test _____	Hepatitis B		_____	_____	_____	_____	_____	_____
Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>	Varicella (chicken pox)		_____	_____	_____	_____	_____	_____

**Staff Profile**

Physical Condition: Excellent Good Fair Poor

Temperament: Timid Quiet Sensitive Average Excitable Aggressive Other \_\_\_\_\_

Adjusts to contemporaries: Very Easily Easily With Difficulty

Participates in group activities: Easily With Encouragement Only When Encouraged

Known Fears or Weakness: \_\_\_\_\_

Eating, Sleeping Habits: \_\_\_\_\_

Any Activity restrictions: \_\_\_\_\_

Special dietary concerns: \_\_\_\_\_

Parent/Guardian or Adult Staff Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Name (Print) \_\_\_\_\_

**MEDICATIONS**

**All medications brought to camp, both prescription and non-prescription, must be in the original containers and clearly labeled with staff's name. All prescription medications will be dispensed according to physician's instructions.**

**Prescription and Routine Medications** – Please list all medications brought by staff to be taken regularly throughout the camp week listing exact dosage and dispensing orders prescribed by your doctor. Medications must be in original containers.

Medication	Dosage	Times Taken (Breakfast, Lunch, Supper, Bed, Other)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent/Guardian or Adult Staff Signature verifying instructions: \_\_\_\_\_ Date \_\_\_\_\_

If dispensing orders differ from original container's label, a Physician's signature is required: \_\_\_\_\_ Date \_\_\_\_\_

**Over-The-Counter Medications** - By **checking** the appropriate box, I give permission for me/my child to receive the following over-the-counter medications according to the specific directions on the product label unless otherwise directed by a physician.

<u>Symptom</u>	<u>Medication</u>
Headache, Fever	<input type="checkbox"/> Acetaminophen (Tylenol)
Cramps, Muscle Pain, Inflammation	<input type="checkbox"/> Ibuprofen
Upset stomach	<input type="checkbox"/> Maalox <input type="checkbox"/> Mylanta <input type="checkbox"/> Tums <input type="checkbox"/> Pepto-Bismol
Diarrhea	<input type="checkbox"/> Kaopectate <input type="checkbox"/> Imodium Liquid
Constipation	<input type="checkbox"/> Milk of Magnesia
Localized Allergic Reactions	<input type="checkbox"/> Benadryl
Sore Throat	<input type="checkbox"/> Sore Throat Lozenge
Itching (Rash)	<input type="checkbox"/> Hydrocortisone Cream <input type="checkbox"/> Calamine Lotion
Insect Sting	<input type="checkbox"/> Insect Bite Relief (Sting Kill) ointment
Mosquito Protection	<input type="checkbox"/> Lotion containing DEET
Sun Burn Protection	<input type="checkbox"/> Sunscreen Lotion

No oral medications will be given without specific parental authorization.

List any over-the-counter oral or topical medications which you/your child should **not** receive.

\_\_\_\_\_

**Parent/Guardian or Adult Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_