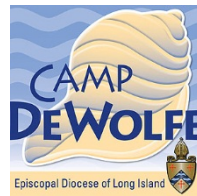


# CAMP DeWOLFE

## STAFF HEALTH HISTORY FORM



Please complete this health form and attach additional information if needed. Please ensure your health-care provider reviews the form and completes and signs their section on page 5. After completion, please sign the form and return it to Camp DeWolfe by June 1<sup>st</sup> 2013.

### HEALTH HISTORY FORM

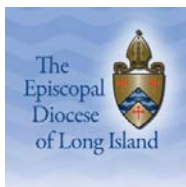
- Full Name: \_\_\_\_\_
- Birth Date: \_\_\_\_\_ Age at camp: \_\_\_\_\_ Gender: Male \_\_\_ Female \_\_\_
- Dates at camp from: \_\_\_\_\_ to \_\_\_\_\_
- Home Address: \_\_\_\_\_
- Home Phone: (        ) \_\_\_\_\_
- Custodial Parent/guardian #1 (Name): \_\_\_\_\_
- Relationship: \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_
- Place of Employment: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_
- Custodial parent/guardian #2 (Name): \_\_\_\_\_
- Relationship: \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_
- Place of Employment: \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_
- If not the above are available in an emergency, notify: \_\_\_\_\_
- Relationship: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_
- Address: \_\_\_\_\_
- Name of family dentist: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_
- Address: \_\_\_\_\_

### INSURANCE INFORMATION

- Are you covered by family medical/hospital insurance? YES\_\_ NO \_\_
  - If YES, indicate Insurance Company: \_\_\_\_\_
  - Policy #: \_\_\_\_\_ Subscriber \_\_\_\_\_
  - Insurance Company Phone Number: \_\_\_\_\_
- (A photocopy of front & back of health insurance cards must be attached to this form)**

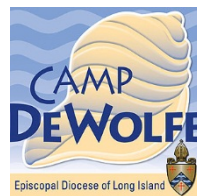
### ALLERGIES

- \_\_\_ No known allergies.
- \_\_\_ Staff is allergic to: (Please describe what the camper is allergic to and the reaction seen)
- \_\_\_ Medicine \_\_\_\_\_
- \_\_\_ Food \_\_\_\_\_
- \_\_\_ The environment - include insect stings, hay fever, asthma, etc. \_\_\_\_\_



# CAMP DeWOLFE

## STAFF HEALTH HISTORY FORM



### MEDICATIONS

Please list ALL routine prescription and over-the-counter or non-prescription drugs (including vitamins). Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Please check:

I take medications as follows  OR  I take NO medications during camp

- Med # 1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_
  - Reason for taking \_\_\_\_\_
  - Med # 2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_
  - Reason for taking \_\_\_\_\_
  - Med # 3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_
  - Reason for taking \_\_\_\_\_
  - *Please attach additional pages for more medications.*
  - Identify any medications taking during the year that you do not take during summer
- 

### AUTHORIZATION FOR STOCK NON-PRESCRIPTION DRUG ADMINISTRATION BY CAMP HEALTH CARE PROVIDER

A Registered Nurse (RN) or Licensed Practical Nurse (LPN) is always available at the Health Center to assist in the assessment of any conditions and to respond appropriately in dispensing these medications/treatments.

Please indicate which of the available non-prescription drugs/ treatments **MAY NOT** be used or given by checking the appropriate boxes on the enclosed list. The Camp DeWolfe physician has approved the non-prescription drugs/treatments listed below for use at camp and we will have these in stock in our Health Center:

### NON PRESCRIPTION TOPICAL MEDICATIONS

( ) denotes use for item  
[ ] denotes active ingredient

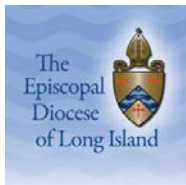
#### Check only if NOT to be given:

- Alcohol Prep. Pads (wound cleaning)
- Aloe Vera Gel (moisturizing therapy)
- Ammonia Inhalants (fainting)
- Anti-fungal powder/spray or cream [Tinactin or similar]
- Anti-microbial wipes (wound cleaning)
- Anti-biotic Ointment / Bacitracin (wound cleaning)
- Betadine Solution (topical antiseptic)
- Calagel / Caladryl / Calamine Lotion (skin irritation relief)
- Foille Medicated First Aid Spray (sunburn / minor burn relief)
- Hydrocortisone Cream 1% (skin irritations)
- Hydrogen Peroxide 3% (wound cleaning)
- Ice Packs
- Mediosine Sting Ease Swabs

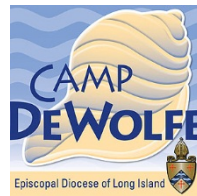
- Medicated Powder (skin irritations)
- Off Skintastic (insect repellent)
- Petroleum Jelly / Vaseline (chapped lips)
- PhisoDerm (skin cleaner)
- Saline Eye Drops (eye irritations)
- Skin So Soft Bug Gard (insect repellent)
- No-Ad Sun Block SPF 30 (sunscreen)
- No-Ad Sun Block SPF 45 (sunscreen)
- Solarepel Sunscreen Spray SPF 25
- Silvadene Cream (burn relief)
- Swimmer's Ear Drops (or ½ alcohol ½ vinegar solution)
- Tecnu Wash (Poison Ivy / Oak)
- Viractin Gel (cold sore medication)
- Witch Hazel (astringent)

Comments: \_\_\_\_\_

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# CAMP DeWOLFE STAFF HEALTH HISTORY FORM



## NON PRESCRIPTION ORAL MEDICATIONS

( ) denotes use for item  
[ ] denotes active ingredient

### Check only if NOT to be given:

- |  |   |
|--|---|
| <input type="checkbox"/> Anbesol Ointment (tooth pain/canker sores)                                    | <input type="checkbox"/> Complete Allergy Medicine Tablets 50mg [Diphenhydramine HCL]   |
| <input type="checkbox"/> Acetaminophen Tablets 500 mg  | <input type="checkbox"/> Chlor Trimeton 4-hour Antihistamine [Chlorpheniramine Maleate] |
| <input type="checkbox"/> Acetaminophen Tablets 325 mg  | <input type="checkbox"/> Cough Suppressant Drops-Cherry                                 |
| <input type="checkbox"/> Acetaminophen Children's Chewable 80 mg                                       | <input type="checkbox"/> Guaiatussin DM Liquid (non-alcohol) (cough suppressant)        |
| <input type="checkbox"/> Anti-Diarrheal Tablets [Loperamide Hydrochloride 2 mg]                        | <input type="checkbox"/> Ibuprofen Tablets 200 mg (pain relief)                         |
| <input type="checkbox"/> Bismuth Tablets (indigestion / diarrhea)                                      | <input type="checkbox"/> Pepto Bismol Tablet [bismuth subsalicylate]                    |
| <input type="checkbox"/> Benadryl Tablets 25 mg (bug bite/poison ivy reactions)                        | <input type="checkbox"/> Pepto Bismol Liquid [bismuth subsalicylate]                    |
| <input type="checkbox"/> Benadryl Tablets 50 mg (bug bite/poison ivy reactions)                        | <input type="checkbox"/> Pseudoval - Nasal Decongestant [Pseudoephedrine HCL 30mg]      |
| <input type="checkbox"/> Benadryl Childrens Liquid (no alcohol) [Diphenhydramine HCL] (allergy relief) | <input type="checkbox"/> Senna Tablets (natural laxative)                               |
| <input type="checkbox"/> Chloraseptic Throat Spray (sore throat relief)                                | <input type="checkbox"/> Sepasoothe Lozenge (anesthetic throat lozenge)                 |
| <input type="checkbox"/> Complete Allergy Medicine Tablets 25mg  | <input type="checkbox"/> Tums (indigestion) [calcium carbonate]                         |

**Comments:** \_\_\_\_\_  
\_\_\_\_\_

I give permission for a Registered Nurse, trained in accordance with the State of New York Health Department regulations and under the authorization of the Camp Physician through the 2012 Camp DeWolfe Standing Orders, to administer non-prescription medications, as indicated above, in accordance with the label directions and with attention to the relevant side effects also listed on the label of the above medications.

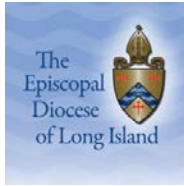
**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### GENERAL QUESTIONS (Explain 'YES' answers below or on separate sheet)

	YES	NO		YES	NO
Has the staff member:			Had mononucleosis during the past 12 months?		
Ever been hospitalized?	___	___	If female, have problems with periods?	___	___
Ever had surgery?	___	___	Have problems with falling asleep/sleepwalking?	___	___
Have recurrent/chronic illnesses?	___	___	Ever had back/joint problems?	___	___
Had a recent infectious disease?	___	___	Ever had high blood pressure?	___	___
Had a recent injury?	___	___	Have a history of bedwetting?	___	___
Had asthma/shortness of breath?	___	___	Have problems with diarrhea or constipation?	___	___
Have diabetes?	___	___	Have any skin problems?	___	___
Had seizures?	___	___	Traveled outside the country in the past 9 mths?	___	___
Had headaches?	___	___	Ever had an eating disorder?	___	___
Wear glasses, contact or protective eyewear?	___	___	Ever had emotional difficulties	___	___
Had fainting or dizziness?	___	___	and sought professional help?	___	___
Had frequent ear infections?	___	___	Ever been diagnosed with a heart murmur?	___	___
Passed out/had chest pain?	___	___			

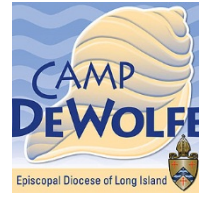
Please explain any "YES" answers, noting the number of the questions: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



# CAMP DeWOLFE

## STAFF HEALTH HISTORY FORM



### STAFF AUTHORIZATION

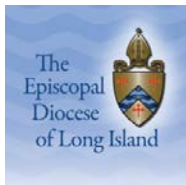
This health history is correct and complete to the best of my knowledge, and I can engage in all camp activities except as noted. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to arrange necessary related transportation for myself. I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for myself. This completed form may be photocopied for trips out of camp.

#### Health Insurance Information... I understand that:

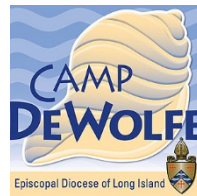
- The Camp DeWolfe staff will make every effort to insure that medical personnel are given my health insurance information at the time of treatment when I have provided copies of the necessary documents;
- Not all medical treatment facilities will file insurance claims. If this situation occurs, Camp DeWolfe will forward the bills to me and I agree to pay them within 60 days of receipt;
- If Camp DeWolfe is required to obtain a prescription, I agree to reimburse Camp DeWolfe for any co-payment or prescription expense;
- Camp DeWolfe will notify an emergency contact if medical attention is sought for me. Camp DeWolfe will follow-up with written notification, along with copies of all documents related to my treatment;
- If I do not have health insurance, or I fail to provide Camp DeWolfe with the necessary documentation for coverage, I agree to pay all medical expenses, including prescriptions incurred.

Signature of staff member: \_\_\_\_\_

Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_



# CAMP DeWOLFE STAFF HEALTH HISTORY FORM



### TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Exam (must be within 12 months of attending) \_\_\_\_\_

Which of the following has the participant had?

- Measles
- Chicken Pox)
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Rubella

TB Mantoux Test

Date of last test \_\_\_\_\_

Results:  Positive  Negative

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ B/P: \_\_\_\_\_ Gross Dental: \_\_\_\_\_

Please give all dates of immunizations for:

Vaccine: Dates? Mo/Yr Mo/Yr Mo/Yr Mo/Yr Mo/Yr

DTP \_\_\_\_\_

TD (Tetanus/Diphth) \_\_\_\_\_

Tetanus \_\_\_\_\_

Polio \_\_\_\_\_

MMR \_\_\_\_\_

Or Measles \_\_\_\_\_

Or Mumps \_\_\_\_\_

Or Rubella \_\_\_\_\_

Haemophilus Infl B \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Varicella (chicken pox) \_\_\_\_\_

\_\_\_ Staff member may participate in all camp activities.

\_\_\_ Staff member may participate with the following restrictions, exceptions or modifications:

Name of family physician: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Office Address: \_\_\_\_\_

**I have reviewed the Camper Health History Form and have discussed the camp program with the staff member. It is my opinion that the staff member is physically and emotionally fit to participate in an active camp program (except as noted above).**

**Signature of Health Care Provider:** \_\_\_\_\_

**Printed Name of Health Care Provider:** \_\_\_\_\_

*Please use a separate sheet to provide any additional information about the participant's behavior & physical, emotional, or mental health about which the camp should be aware.*

