

CAMP FITCH YMCA HEALTH FORM for STAFF 2010 Update

DATE(S) ATTENDING _____

Staff: Please give complete information below so the camp is aware of your needs and has the information necessary for appropriate care. Please mail a copy of this form before your first week at camp, bring a back-up copy with you upon check in and maintain a copy for your own records. If there are changes after you send us the form, please notify the nurse upon arrival at camp.

Note: Please return this form directly to: Camp Fitch YMCA, 12600 Abels Rd, North Springfield, PA 16430 or fax to 814-922-7000

Last Name _____ First _____ M.I. ____ Nickname _____

Birth date: ____/____/____ M F

Custodial parent/guardian _____ Home Phone: (____) _____

Home address _____ City, State, Zip _____

Work Phone (____) _____ Cell Phone (____) _____

Second parent/guardian _____ Home Phone: (____) _____

Home address _____ City, State, Zip _____

Work Phone (____) _____ Cell Phone (____) _____

If under 18, please indicate who the staff member lives with _____

If neither of the above are available in an emergency, please notify:

Alternate contact #1: Name _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Alternate contact #2: Name _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Name of Family Physician: _____ Phone:(____) _____

Name of Dentist/Orthodontist: _____ Phone: (____) _____

Do you have medical/hospital insurance? _____ If yes, Policy Holders Name _____

Employer through which insurance is obtained: _____

Carrier: _____ Policy or Group # _____

Do you have prescription drug insurance? _____ If yes, Policy Holder's Name: _____

Carrier: _____ Policy or Group # _____

Please attach a copy of both sides of your insurance card. Without this attachment, treatment can be delayed.

IMPORTANT - MUST BE COMPLETED FOR ATTENDANCE

Authorization: This health history is correct so far as I know, and the person herein described has permission to engage in all camp activities, except as noted by the examining physician and/or I. I understand there are some inherent risks in activities at camp and accidents sometimes occur. I understand that the camp accident insurance is only supplementary to my insurance. I hereby give permission to the physician selected by the camp director to order x-rays, routine tests and treatment for my health and in the event I am unconscious and it is an emergency, I hereby give permission to anesthesia and/or surgery. I agree to remain at camp for the duration of my contract unless necessary to withdraw due to illness as defined by the camp physician. I give permission for Camp Fitch YMCA to use my likeness in photos or videos for promotional literature.

Staff Member Signature _____ Date _____

Print Name _____ Witness Signature _____

Parent/Guardian Signature (if staff member under 18) _____

Please turn over to complete the form

LAST NAME:

FIRST NAME:

STAFF MEDICAL HISTORY - TO BE FILLED OUT BY PARENT (if under 18) or SELF

Health History: (check - giving approximate dates).

Allergies

Diseases

_____ Frequent ear infections
_____ Heart Defect/Disease
_____ Convulsions
_____ Diabetes (onset)
_____ Bleeding/Clotting Disorders
_____ Epilepsy (onset)
_____ Tonsillitis

_____ Hay Fever
_____ Poison Ivy etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Peanuts
_____ Other Foods

_____ Rheumatic Fever
_____ Chicken Pox
_____ Measles
_____ German Measles
_____ Mumps
_____ Asthma
_____ Strep Throat
_____ Mononucleosis

Other diseases or detail of the above: _____

Operations or serious injuries (dates): _____

Chronic or recurring illness or Special Needs: _____

(For girls) Is your menstrual history normal? _____

Special considerations or suggestions: _____

The Camp Fitch Health Center is well stocked with over-the-counter non-prescription medications. Are there any over-the-counter, non-prescription medications or ointments that **SHOULD NOT** be given to staff member?

MEDICAL EXAMINATION - TO BE FILLED OUT BY LICENSED PHYSICIAN

This examination should be performed within 12 months of arrival at camp. Examination for some other purpose within this period is acceptable. Examination is for determining ability to engage in strenuous activities. Laboratory tests done at discretion of physician.

CODE: V = Satisfactory; X = Not satisfactory (explain); O = Not examined

Height: _____ Weight: _____ BP: _____ Resting Pulse: _____

_____ Eyes _____ Lungs Allergies (please specify): _____

_____ Glasses _____ Abdomen _____

_____ Ears _____ Hernia _____

_____ Nose _____ Extremities General Appraisal: _____

_____ Throat _____ Posture (spine) _____

_____ Heart _____ Skin _____

Date of last tetanus vaccine: _____

Immunizations are up-to-date: ___ Yes ___ No If No, Reason: _____

Recommendations and restrictions while at camp:

Swimming/diving _____ Strenuous Activity: _____

Other: _____ Special Diet: _____

Current medications (list name, dosage and time schedule): All medications must be in a correctly labeled original container and given to the nurse at check-in time. **NO MEDICATIONS (PRESCRIPTION OR OVER-THE-COUNTER) WILL BE ALLOWED IN THE CABENT/LODGE UNLESS AUTHORIZED BY THE NURSE.**

I have examined this person herein described and have reviewed the health history. It is my opinion that this camper is physically able to engage in camp activities, except as noted.

Doctor signs here: _____ **M.D. Date** _____

Address: _____

Phone: (_____) _____ **Fax:** (_____) _____