

Chronic Concerns: Check all that pertain to you and provide information about supportive health care. **Asthma or Diabetes? Complete additional form available [insert information here].*

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s): Asthma* Headaches/Migraines Sleep problem Diabetes*
 Difficult breathing Dysmenorrhea Fainting Surgery history Seizure disorder: _____
 Back pain or injury Knee or ankle weakness Other: _____

Provide information about supportive healthcare needed for each checked item:

Immunization History: Provide the month & year for immunizations. **ASTERISKED (*) IMMUNIZATIONS MUST BE CURRENT.**

Immunization	Date — Month(s) & Year(s)	Immunization	Date — Month(s) & Year(s)
Tetanus Booster*	Current within 10 years:	Polio*	
Varicella (Chicken Pox) <input type="checkbox"/> Had the disease / date	Recommended	MMR (Mumps, Measles, Rubella)*	
Meningitis	Recommended	Pneumococcal	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	DPT (diphtheria, tetanus, pertussis)*	
Hepatitis B		Hepatitis A	
Influenza	Recommended		
H1N1	Recommended		

Medication: Bring enough medication to last or bring your written prescription to order a refill. Prescription meds **MUST** be in pharmacy containers with appropriate labels; other remedies must be in original container. International Staff: translate information to English.

_____ I do not take medication on a routine basis.

_____ I take routine medication (include vitamins) as noted below.

Name of Medication	Reason for Taking It	Dose Given & When	Date Started?
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	

General Physical History

1. Have you ever been hospitalized? Yes No
Have you ever had surgery? Yes No
2. Have you ever passed out during or after exercise/physical exertion? Yes No
Have you ever been dizzy during or after exercise/physical exertion?..... Yes No
Have you ever had chest pain during or after exercise/physical exertion?..... Yes No
Do you tire more quickly than your friends during exercise/physical exertion? Yes No
Have you ever had high blood pressure?..... Yes No
Have you ever been told that you had a heart murmur?..... Yes No
Have you ever had racing of your heart or skipped heartbeats?..... Yes No
3. Do you have skin problems (itching, rashes, acne)? Yes No
4. Have you ever been knocked out, fainted, or become unconscious? Yes No
Have you ever had a seizure? Yes No
Have you ever had a stinger, burner, or pinched nerve? Yes No
5. Have you ever had heat or muscle cramps? Yes No
Have you ever been dizzy or passed out in the heat? Yes No

6. Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of your body areas?
..... Yes No

If so, where? Head Shoulder Thigh Neck Chest Forearm Shin/calf
 Back Wrist Hand Ankle Elbow Knee Hip Foot

Can you lift and carry 30 pounds (14 kilograms) at least ten times without assistance or discomfort?..... Yes No

7. Have you had chicken pox or are you immunized for chicken pox?..... Yes No
8. Have you had mononucleosis in the past nine months? Yes No
9. Do you have an uncorrected hearing problem?..... Yes No
Do you have an uncorrected vision (sight) problem?..... Yes No
Do you wear glasses or contacts or use protective eye wear? Yes No
10. Do you smoke and/or use other tobacco products? Yes No
11. Do you have any piercings?..... Yes No

If so, where? Ears Eyebrow Nose Tongue Belly Button Nipple Other: _____

12. Do you have any problems with your teeth?..... Yes No

13. Have you been in countries other than the United States in the past nine months?..... Yes No

If yes, list the countries and the length of time spent in them.

Country: _____ Dates: _____

Country: _____ Dates: _____

Country: _____ Dates: _____

14. For women: Do you have a menstrual problem (pain, irregularity, etc.)? Yes

No

Explain and/or provide more detail about the General Physical Health questions to which you responded "yes."

Name of your physician: _____ Office Phone: (_____) _____

Name of your dentist/orthodontist: _____ Office Phone: (_____) _____

Mental & Emotional Health Information

- A. Have you been diagnosed with attention deficit disorder (ADD) or AD/HD. Yes No
- B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work? . . . Yes No
- C. Do you have an eating disorder that will impact your work? Type: _____ Yes No
- D. Do you have a learning disability that will impact your work? Type: _____ Yes No
- E. Do you have an emotional health concern that will impact your work? Yes No
- F. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?

If "yes" to any question in this section, attach a statement that:

- (a) Describes the concern and your management plan for addressing it while working at camp; and
- (b) Describes the support needed from your work supervisor to compliment your plan. Refer to the Essential Functions of your job, available [insert location], if there are questions.

Paying for Health Care:

- There is usually no charge for health care provided by the camp's Health Center staff.
- Staff are financially responsible for health care provided by out-of-camp providers.
- If you will be using personal insurance while working at camp, it is your responsibility to know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

Emergency Contact: Whom do you want us to contact in an emergency?

First Contact: _____ Phone: (_____) _____

Relationship to You: _____

Alternate Contact: _____ Phone: (_____) _____

Relationship to You: _____

Authorization for Health Care: Parental signature required for staff less than 18 years of age.

This health history is correct insofar as I know. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp Health Center staff in providing care to me and may be reviewed by work supervisor.

Signature of Staff Person: _____ Date: _____

Signature of Parent (if needed): _____ Date: _____