

STAFF MEMBER'S NAME _____ DATE OF BIRTH _____ AGE AT CAMP _____

MALE / FEMALE

Camp Eagle Hill STAFF Medical Form

NOTIFICATION INFORMATION:

STAFF MEMBER'S HOME ADDRESS

Street City State Zip

PARENT or GUARDIAN _____

HOME ADDRESS _____ HOME PHONE () _____

Street City State Zip

WORK ADDRESS _____ WORK PHONE () _____

Street City State Zip

CELL PHONE () _____

SECOND PARENT or GUARDIAN _____

HOME ADDRESS _____ HOME PHONE () _____

Street City State Zip

WORK ADDRESS _____ WORK PHONE () _____

Street City State Zip

CELL PHONE () _____

EMERGENCY CONTACT (IF PARENTS or GUARDIANS UNAVAILABLE) _____

Relationship to Staff Member _____

Home Address _____ HOME PHONE () _____

Street City State Zip

WORK PHONE () _____ CELL PHONE () _____

MEDICAL CONSENT FORM (to be signed by Staff Member, parent or guardian)

Our physician's office and any hospital requires us to have on hand a permission form which will permit our physician or a hospital's physician to treat a Staff Member in our physician's office or on the hospital's premises.

I hereby give permission to the Camp Director or medical personnel selected by the Camp Director to order x-rays, routine tests, treatment, and necessary transportation for me (or "my child" if Staff Member is under 18 years of age) in the event I, the Staff Member, am in need of a hospital's care, or if my parents (if Staff Member is under 18 years of age) cannot be reached, in the event of an emergency. I hereby give permission to the physician selected by the camp director to secure and administer treatment, including any hospital care or hospitalization, for me (or my child), as named above. I do also permit the camp medical staff to dispense any physician prescribed medications or "over the counter" medications to me, needed for medical treatment, unless specified above. I do further give permission to dental personnel selected by the camp director to perform needed dental work on me or "my child" (if Staff Member is under 18 years of age). This completed medical form (both sides) may be photocopied for use on trips out of camp.

Parent's/Guardian's Signature _____ Date _____ Medical Insurance Co. Name _____

Parent's/Guardian's Printed Name _____ Medical Insurance #: _____ Dental Ins. #: _____

MEDICATIONS TO BE TAKEN AT CAMP (to be filled in by physician)

(Please list all medications, including all over-the-counter or non-prescription drugs, taken routinely or as needed (PRN). We ask that you please bring along enough medication for your stay at camp. In addition, please keep any medication in original packaging so that the original bottle can identify the prescribing physician (in the case of prescription medication). This way we will also be able to see the name of the medication, the dosage to be taken, and the frequency of administration.

MEDICATION #1: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking

MEDICATION #2: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking

MEDICATION #3: _____ **Dosage** _____ **Specific Times Taken Each Day** _____

Reason For Taking

MEDICAL EXAMINATION (to be filled in by physician) **STAFF MEMBER'S NAME** _____

Height _____ **Weight** _____ **BP** _____ **Hgb.** _____ **Urinalysis** _____

1. This staff member is under the care of a physician for the following conditions:

2. Please state any physical disability that this staff member has:

3. Has this staff member had any surgery? If yes, for what, and when?

4. Has this staff member ever had any serious illnesses? If yes, what type, and when?

5. Has this staff member had any recurring illnesses? _____
6. Are there to be any restrictions for this staff member while in camp? _____
7. Are swimming and diving permitted? _____
8. Is strenuous activity permitted? _____
9. Any additional health information or special instructions for this staff member? _____
10. Any treatment to be continued at camp? _____
11. Any medically prescribed meal plan or dietary concerns? _____
12. Any special instructions for the camp? _____

I have examined _____ and have reviewed his/her health history. This health history is correct so far as I know. It is my opinion that he/she is physically able to engage in camp activities, except as noted.

Date of Form Completion _____ **Examining Physician's Signature** _____ **M.D.**

EMERGENCY MEDICAL INFORMATION and HEALTH HISTORY (To Be Filled in by Staff Member with Physician)

EMERGENCY MEDICAL INFORMATION

1. Will staff member have an epinephrine pen at camp? (circle one) YES NO

If so, for what condition?

2. Is staff member allergic to any foods, medications, plants, animals, or insects? (circle one) YES NO

If so, what is staff member allergic to?

3. Is staff member asthmatic or does he/she have any condition that requires any special care, medication, or diet? (circle one) YES NO

If so, what condition and what kind of care is needed? _____

GENERAL MEDICAL QUESTIONS

Has/does the staff member: YES NO YES NO

- | | | | | | |
|---------------------------------------------------------|-----|----|---------------------------------------------------------------------------------------|-----|----|
| 1. Had any recent injury or infectious disease? _____ | YES | NO | 21. Wear braces or have any special caps/crowns on teeth? _____ | YES | NO |
| 2. Have a chronic or recurring illness/condition? _____ | | | 22. Have an orthodontic appliance being brought to camp? _____ | | |
| 3. Ever been hospitalized? _____ | | | 23. Have any skin problems? (e.g.- itching, rash, acne) _____ | | |
| 4. Ever had surgery? _____ | | | 24. Have diabetes? _____ | | |
| 5. Have frequent headaches? _____ | | | 25. Had problems with diarrhea or constipation? _____ | | |
| 6. Ever had a head injury? _____ | | | 26. Had mononucleosis in the past 12 months? _____ | | |
| 7. Ever been knocked unconscious? _____ | | | 27. Have done any sleepwalking? _____ | | |
| 8. Wear glasses, contacts, or protective eyewear? _____ | | | 28. Have a history of bedwetting? _____ | | |
| 9. Ever had frequent ear infections? _____ | | | 29. Ever had an eating disorder? _____ | | |
| 10. Ever passed out during or after exercise? _____ | | | 30. Ever had any emotional difficulties for which professional help was sought? _____ | | |
| 11. Ever been dizzy during or after exercise? _____ | | | 31. For female staff, has menstruation begun? _____ | | |
| 12. Ever had seizures? _____ | | | 32. Any special considerations concerning menstruation? _____ | | |
| 13. Ever had chest pain during or after exercise? _____ | | | | | |
| 14. Ever had high blood pressure? _____ | | | | | |
| 15. Ever been diagnosed with a heart murmur? _____ | | | | | |
| 16. Ever had heart defects/disease? _____ | | | | | |
| 17. Ever had bleeding/clotting problems? _____ | | | | | |
| 18. Ever had rheumatic fever? _____ | | | | | |
| 19. Ever had back problems? _____ | | | | | |
| 20. Ever had problems with knees or joints? _____ | | | | | |

Please explain any "yes" answers, noting the number of the questions:

Physician's Name (printed) _____ Dentist's Name (printed) _____

Physician's Address _____

Dentist's Address _____

Physician' Phone Number () _____ Dentist's Phone Number () _____