

2010 STAFF HEALTH HISTORY FORM

Name _____ Birthday ____/____/____ Age ____ Sex ____
 Last First Middle Initial
 Parent or Guardian _____ Camper Social Security # _____
 Home Address _____ City _____ State _____ Zip _____ Phone _____
 Second Parent or Guardian or Emergency Contact _____
 Home Address _____ City _____ State _____ Zip _____ Phone _____
 Business _____ Phone _____
 If not available in an emergency, notify: _____
 Name _____ Relationship to You _____
 Address _____ Phone _____

Health History

- (Give approximate date.)
 Frequent Ear Infections
 Heart Defect/Disease
 Seizures
 Diabetes
 Bleeding/Cotting Disorders
 Hypertension
 Mononucleosis
 Psychiatric Treatment
 Recent Head Lice Infestation
 Frequent Sore Throats
 Stomach Upsets
 Bed Wetting
 Sleepwalking
 Menstrual Problems

Diseases

- Chicken Pox
 Measles
 German Measles
 Mumps

Allergies (Date not needed.)

- Hay Fever
 Ivy Poisoning, etc.
 Insect Stings (How Severe)
 Penicillin
 Other Drugs
 Asthma
 Other (specify) _____

Immunization History - Please record the date (month and year) of basic immunizations and most recent booster doses. A photocopy of the current immunization history will be accepted.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria		
Pertussia (Whooping Cough)		
Tetanus		
Tetanus		
Diphtheria		
Tetanus		
Oral polio (Sabin)		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubcola)		
Mumps		
Rubella (German measles, 3 - day measles)		
other		
Tuberculin Test Given (Most recent)		
Haemophilus influenza b		

Operations or serious injuries (dates) _____
 Disability or chronic or recurring illness _____
 Physical, emotional or mental handicaps _____
 Activities encouraged or limited by physician _____
 Dietary modifications _____
 Current medication (send with instructions) _____
 Other diseases or details of above _____
 Name of dentist/orthodontist _____ Phone _____
 Name of family physician _____ Phone _____
 Do you carry family medical/hospital insurance? _____yes_____no
 If so, indicate: Carrier _____ Policy or Group # _____
 Suggestions on health related information for camp personnel _____

Is there anyone who is legally restricted from seeing the camper? _____yes_____no
 If yes, Name _____ Relationship to Camper _____

- **By signing this health form, I certify that the above named camper has received a physician's health examination within the past 24 months and has been cleared to participate in all camp activities.** Date of Last Physical Examination: _____
 Physician who performed exam: _____ Phone _____

I hereby certify that the health history information provided for the camper named above is correct so far as I know, and the person named herein has my permission to engage in all prescribed camp activities except as noted. **Authorization for Treatment:** I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to Black Rock Retreat Health Care Staff to administer over the counter, non prescription medications such as Tylenol, Ibuprofen, cough syrup, antacids, etc. as needed. I give permission to the Health Care Manager and staff selected by Black Rock Retreat Personnel to administer prescribed medication as listed on this form, to perform treatment for minor injuries and illnesses, and to perform First Aid or CPR in the event of a more serious injury or illness. In the event I cannot be reached during an emergency, I hereby give permission for personnel selected by Black Rock Retreat to provide emergency care and treatment to the above named camper in the event of injury or illness. I also give permission for Black Rock personnel to secure needed professional medical treatment by a physician, EMS or Emergency Room hospital staff as needed and to order X-rays, routine tests, treatment, and any necessary related transportation for me/or my child.

*Signature of parent or guardian or camper if not a minor _____
 Witness _____ Date _____

*If for religious reasons you cannot sign this, then the camp should be contacted for a legal waiver, which must be signed for attendance.