CAMP SCULLY
STAFF HEALTH EVALUATION FORM

Return this form no later than date in box in right corner to:

Catholic Charities Human Resources
40 North Main Avenue
Albany, New York 12203

STAFF MUST COMPLETE SECTIONS 1-5. PHYSICIAN MUST COMPLETE SECTIONS 6.

SECTION 1: IDENTIFYING INFORMATION

Staff Name: _____ DOB: _____ Gender: _____

Home Address _____
Street Address City/Town State Zip Code

SECTION 2: PEOPLE TO CALL IN CASE OF EMERGENCY

Name _____ Relationship _____

Phone Numbers (Home, Work, Cell): _____

Name _____ Relationship _____

Phone Numbers (Home, Work, Cell): _____

SECTION 3: HEALTH INSURANCE INFORMATION

Are you covered by medical/hospital insurance? ❒ Yes ❒ No

If so, indicate carrier or plan name _____ Group # _____

Name of insured _____ Relationship to staff _____

Social security number of policy holder or insurance ID number _____

PHYSICIAN INFORMATION

Name of family physician _____ Phone _____

Address _____

Name of family dentist/orthodontist _____ Phone _____

Address _____

Hospital of preference _____

SECTION 4: HEALTH HISTORY

ALLERGIES (list all known and describe reaction and what you do for reaction)

Medications _____

_____

Food _____

_____

Other allergies (insect stings, hay fever, asthma, animals, etc.) _____

_____

RESTRICTIONS

Dietary

❒ Does not eat red meat ❒ Does not eat pork ❒ Does not eat eggs
❒ Does not eat poultry ❒ Does not eat seafood ❒ Does not eat dairy products
❒ Other (describe) _____

Activity (explain any restrictions – what cannot be done, what adaptations or limitations are necessary)

_____

_____

GENERAL QUESTIONS (explain "yes" answers below)

Have you:	**Yes**	**No**
1. Had any recent injury, illness or infectious disease	❑	❑
2. Have a chronic or recurring illness/condition?	❑	❑
3. Ever been hospitalized?	❑	❑
4. Ever had surgery?	❑	❑
5. Have frequent headaches?	❑	❑
6. Ever had a head injury?	❑	❑
7. Ever been knocked unconscious?	❑	❑
8. Wear glasses, contacts or protective eyewear?	❑	❑
9. Ever had frequent ear infections?	❑	❑
10. Ever passed out during or after exercise?	❑	❑
11. Ever been dizzy during or after exercise?	❑	❑
12. Ever had seizures?	❑	❑
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 back problems?	❑	❑
17. Ever had problems with joints (e.g., knees, ankles)?	❑	❑
18. Have an orthodontic appliance being brought to camp?	❑	❑
19. Have any skin problems (e.g., itching rash, acne)?	❑	❑
20. Have diabetes?	❑	❑
21. Have asthma?	❑	❑
22. Had mononucleosis in the past 12 months?	❑	❑
23. Had problems with diarrhea/constipation?	❑	❑
24. Have problems with sleepwalking?	❑	❑
25. If female, have an abnormal menstrual history?	❑	❑
26. Have a history of bed wetting?	❑	❑
27. Ever had an eating disorder?	❑	❑
28. Ever had emotional difficulties for which professional help was sought?	❑	❑

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

_____

_____

_____

SECTION 5: STAFF AUTHORIZATIONS:

*** IMPORTANT – THESE BOXES MUST BE COMPLETE FOR ATTENDANCE ***

Staff Authorizations: This health history is correct and complete as far as I know. The person herein described may engage in all camp activities except as noted by physician. I hereby give permission to the camp to provide routine health care 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 me. In the event I cannot speak for myself in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for me. This completed form may be photocopied for trips out of camp. I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of staff _____

Printed Name _____ Date _____

SECTION 6: HEALTH CARE RECOMMENDATIONS BY LICENSED FAMILY PHYSICIAN

I examined this individual on _____. (Please note: If the staff's last physical exam was between June 1, 2013 and May 31, 2014, a new exam is not necessary. In all other cases, a new one is needed.)

BP _____ Weight _____ Height _____

In my opinion, the above staff person: ❒ is ❒ is not able to participate in an active camp program.

The staff is under the care of a physician for the following conditions: _____

_____

_____

Any medically-prescribed meal plan or dietary restrictions _____

_____

Description of any limitation or restriction on camp activities: _____

_____

_____

Additional information for health care staff at the camp about the staff: _____

_____

STANDING INDIVIDUALIZED ORDERS FOR:

Name: _____ DOB _____ Weight _____

Please list ALL medications taken routinely. The staff person is expected to bring enough medication to last the entire time at camp. Medication must be kept in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration.)

❒ Patient takes no medications on a routine basis. ❒ Patient takes medications as follows:

Prescription Medications: Please complete with patient's current regimen for both scheduled and PRN medications:

Drug Name	Route	Dosage	Schedule and Indications	Comments

IMMUNIZATION HISTORY (Print out of patient's vaccination record from physician is acceptable to address below):

Which of the following has the participant had?

❒ Measles
❒ Chicken Pox
❒ German Measles
❒ Mumps
❒ Hepatitis A
❒ Hepatitis B
❒ Hepatitis C

❒ TB Mantoux Test
Date of last test: _____
Result: ❒ Positive ❒ Negative

Please give all dates of immunization for:

Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	_____
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus Influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (Chicken Pox)	_____	_____				

Camper/Staff Health Care Provider Name: _____

Address: _____ **Phone:** _____

Signature: _____ **License #:** _____

Date: _____