Health History Form

As a counselor or support staff member you are required to bring this health form with you to camp. This health form does not affect your camp's decision to hire you, however, falsifying or failing to disclose *information about your health* may result in dismissal. If you have any questions or concerns about completing this form, contact a Director. If additional space is needed, please attach a separate sheet .

PERSONAL INFORMATION

Name_____ Birth Date_____ Sex: ☐ Male ☐ Female
Last First

Home Address_____ _____
Number & Street City St. Zip Code

Home Phone #_____ School Phone # _____

Emergency Contact_____Relationship_____ _____

Emergency Contact Home Phone #_____Work Phone #_____

Alternate contact in case of emergency:

Name_____ Phone #_____ _____

HEALTH HISTORY-APPLICANT COMPLETE THIS SECTION

Check all that apply and give approximate date of illness

	Date
____ Frequent ear infections	
____ Heart defect/disease	
____ Convulsions	
____ Diabetes	
____ Bleeding disorders	
____ Hypertension	
____ Mononucleosis	
____ Sinus trouble	
____ Migraine headaches	

Allergies	**Date**
____ Poison Ivy/oak	
____ Insect stings	
____ Hay fever	
____ Penicillin	
____ Other drugs	
____ Asthma	
____ Food (specify below)	

Diseases	**Date**
____ Measles	
____ Chicken Pox	
____ German Measles	
____ Tuberculosis	
____ Hepatitis	
____ Mumps	
____ Bronchitis	

List surgeries or major illnesses you have had in the last 18 months (include dates):
_____
_____

List any chronic health concerns which affect your ability to work:
_____

What can your employer do to facilitate your performance?
_____
_____

Have you ever been under a professional's care for emotional, psychological or learning difficulties? ☐Yes ☐No If yes, please describe_____
_____

Do you smoke? ☐Yes ☐No

Can you do the following without difficulty?

Push	☐Yes	☐No
Pull	☐Yes	☐No
Walk	☐Yes	☐No
Run	☐Yes	☐No
Bend	☐Yes	☐No
Lift	☐Yes	☐No

Insurance Information

Is the staff member covered by medical/hospital insurance?

☐ **Yes** ☐ **No**

If so, indicate carrier or plan name

_____

#_____

Carrier Address: _____

_____

If you answered no to any of the above activities, please explain:_____
_____
_____
_____

This information is valid with regard to my current health status. I understand and agree that if this information is incorrect or I am not able to follow the health guidelines set by my camp, I risk dismissal from Camp Wildwood. If a change in my health status occurs, I agree to notify the camp in writing of that change prior to arriving.
I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization

Applicant's Signature_____ Date_____ _____

IMMUNIZATION HISTORY-MUST BE COMPLETED WITH A LICENSED PHYSICIAN

Please record the month and year of Immunizations.

Vaccines	**Date of Immunization**
***Required Immunizations**	
DPT series* (Diphtheria, Pertussis, Tetanus.)	
Polio*	
MMR (Mumps, Measles, Rubella)*	
Tetanus Booster*	
Typhoid	
Hepatitis B	
Tetanus	
Small Pox	
H1N1	
COVID -19	

Tuberculin test given: (date) _____ Results: ☐ Positive* ☐ Negative

'If your test was positive you must have a chest x-ray and submit the results with your medical form.

MEDICAL EXAMINATION-MUST BE COMPLETED BY A LICENSED PHYSICIAN

Note to examining physician: This person has applied for a program as a camp supervisor/leader of children. This program involves rigorous physical activity and long working hours. Your exam should be directed to the person's fitness to engage in such a program.

Height_____ Weight_____ Does this person wear glasses or contact lenses?_____

Please use the following code when completing your examination:

S = Satisfactory X = Not Satisfactory 0 = Not Examined

_____ Eyes	_____ Heart	_____ Lungs
_____ Ears	_____ Spine	_____ Extremities
_____ Nose	_____ Urinalysis	_____ Blood Pressure
_____ Teeth	_____ Skin	_____ HgB
_____ Abdomen	_____ Throat	

Is this person on any medications that she/he will need to bring to camp ? (please describe)_____
_____
Please rate the overall muscular skeletal condition of this person:_____
Back:_____
Knees:_____
Ankles:_____

Use this space to provide any additional Information about the participant's behavior and physical, emotional, or mental health which the camp should be aware of.

_____
_____
_____

I have examined the above applicant and have reviewed her/his health history. It is my opinion that she/he: (circle) IS IS NOT Physically able to engage in the rigors of camp.

Licensed Examining Physician's Signature_____ Date_____

Physician's Name (please print) _____ Phone_ _____

Address_____
Number & Street City St Zip Code