Health History Form for Camp Employee/Volunteer

Return this completed form to:

The Barn at Spring Brook Farm

360 Locust Grove Rd.

West Chester, PA 19382

Please submit by May 13,2022

Name: _____
First Middle Last

Birthdate: _____

Permanent Address: _____
Street Address

_____
City State/Country Zip/Code

E-mail: _____

Is this your first year as a staff member? ☐ No ☐ Yes

- *Return this form to our camp office at least four weeks prior to your arrival. People hired within four weeks of their start date should not send this form; bring it with you and give it to the Health Center staff at camp.*
- *Notify the camp director if you are exposed to a communicable disease within three weeks of beginning your job.*
- *The camp expects that you arrive in good health and capable of performing the essential functions of your position. If you have questions regarding this, speak with the camp director prior to arrival.*
- *Information on this form is available to Health Center staff and your work supervisor(s) as necessary.*

If you have questions about our camp health services, please call our office.

Allergies: *Check those that apply to you. Completion of this section is voluntary, yet helpful to healthcare staff.*

_____ I have no known allergies.

_____ I have an allergy to this food: _____

This causes anaphylaxis? ☐ Yes ☐ No

Describe what happens if you eat this food and how the reaction is managed:

_____

_____

_____ I am allergic to this medication(s): _____

This causes anaphylaxis? ☐ Yes ☐ No

_____ I am allergic to these substances: _____

This causes anaphylaxis? ☐ Yes ☐No

Describe what happens if you eat this food and how the reaction is managed:

_____

_____

***Please include any allergy emergency plan with this form**

Your supervisor expects that staff who have chronic health concerns are capable of performing the essential functions of the job for

Chronic Concerns: *Check all that pertain to you and provide information about supportive healthcare. Completion of this section is voluntary, yet helpful to healthcare staff.*

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s):

☐ Asthma	☐ Headaches, Migraines	☐ Sleep problem
☐ Diabetes	☐ Difficulty breathing	☐ Dysmenorrhea
☐ Fainting	☐ Surgical history	☐ Seizure disorder: _____
☐ Back pain or injury	☐ Knee or ankle weakness	☐ Other:_____

***Please include any seizure, diabetes and/or asthma plan with this form**

Immunization History:

Date (month/year) of your most recent tetanus immunization:

_____

Have you completed the immunizations that were required for school attendance? ☐ Yes ☐ No

Medication: *All medication must be kept with the nurse unless in the immediate possession/control of the user. All medication should be originally submitted to the Health Center.*

NOTE: Health Center staff will ask about your medication(s) to determine if the use (or non-use) of such medication will impair completion of the essential functions of your job. They may also ask about medication when you seek healthcare. Providing additional information about your medication is voluntary.

Any medication, including both daily and as needed medications, must be accompanied by an order from your physician with administration instructions.

Name of your physician: _____

Office Phone (_____)_____

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

First Contact:_____ Preferred Phone: (_____)_____

Relationship to you: _____

Alternate Contact:_____ Preferred Phone: (_____)_____

Relationship to you: _____

Authorization for Healthcare: *Parental signature required for staff/volunteer under 18 years of age.*
This health history is correct. 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's Health Center staff in providing care to me and may be reviewed by my work supervisor(s).

This health history is correct and accurately reflects the health status of the counselor to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of Participant or Parent/Guardian (if under 18) _____ _____
Date : _____