STAFF HEALTH FORM Complete Both Sides

Mail to the address at the bottom of the page by:

PRINT & USE DARK INK 2 weeks before session of counseling

Camper or Staff Member's Name _____ Session # _____

Home Phone (_____)_____ Date of Birth _____ Age _____ Gender ____ Session Name _____

Address _____ City _____ State _____ Zip _____

Camper Lives with: Both Parents _____; Mother _____; Father _____; Other _____

Parent/Guardian #1 _____ Parent/Guardian #2 _____

Work Phone (_____)_____ Work Phone (_____)_____

Cell/Other Phone (_____)_____ Cell/Other Phone (_____)_____

EMERGENCY CONTACTS (For use if Parent/Guardian cannot be reached)

Name _____ Relationship _____ Phone (_____)_____

Name _____ Relationship _____ Phone (_____)_____

Name of Family Physician _____Phone (_____)_____

Name of Dentist/Orthodontist _____Phone (_____)_____

Medical/Hospital Insurance: Carrier _____ **Dental Insurance:** Carrier _____

**** PLEASE INCLUDE A COPY OF INSURANCE CARDS (Front & Back) WITH HEALTH FORM ****

Description of any LIMITATION or RESTRICTIONS on Camp Activities _____

_____

IMMUNIZATION HISTORY: Record the date (month & year) of Basic Immunization and most recent Booster does **OR** Attach a copy of your child's school/clinic/physician immunization record.

VACCINES	YEAR of Basic Immunization	YEAR of Last Booster
Diphtheria Pertussis (whooping cough) DPT* Tetanus **OR**	1 2 3	1 2
Tetanus Diptheria TD* **OR**		
Tetanus		
Oral Polio (Sabin)* TOPV	1 2 3	
Measles (hard measles, red measles, rubeola		
Mumps		
Rubella (German measles, 3-day measles)		
Other – specify		
Haemophilus influenza b (HIB)		
Hepatitis B		

Date of most recent Tuberculin Test _____ Results _____ Date of Last Tetanus Booster _____

IMPORTANT – This section must be completed for camp attendance.

THIS HEALTH FORM is correct and complete as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted on this form.

PERMISSION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS: I hereby give permission for Camp Mo-Val to administer over-the-counter medications if the health care manager deems it necessary, except as noted by me on this form. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

PERMISSION TO PROVIDE TREATMENT: I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays, routine tests and treatment. I agree to the release of any records necessary for insurance purposes. I give permission to the camp to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

SIGNATURE OF PARENT / LEGAL GUARDIAN
OR ADULT CAMPER / STAFF MEMBER _____ **DATE** _____

WITNESS _____ **DATE** _____

I also understand and agree to abide by the restrictions placed on my camp activities.

SIGNATURE OF MINOR OR
ADULT CAMPER / STAFFER _____ **DATE** _____

Mail To: Camp Mo-Val & Outdoor Ministries 2659 Camp Mo-Val Road Union MO 63084

NAME OF CAMPER:_____ **Date of last Physical Exam:**_____

HEALTH HISTORY: **Camper's current weight:**_____

(Please answer Yes or No; if Yes give approximate dates.)

Allergies:							
_____Frequent Ear Infections	_____Hypertension	_____Chicken Pox		_____Poison Ivy/Oak	_____Asthma	_____Hay Fever	
_____Heart Defect/Disease	_____Mononucleosis	_____Measles		_____Benedryl	_____Insect Stings		
_____Epilepsy/Convulsions	_____Diabetes	_____German measles		_____Penicillin	_____Bee Stings		
_____Psychiatric Treatment	_____Fainting/Dizzy Spells	_____Mumps		_____Other Drugs (specify):_____			
_____Bleeding/Clotting Disorders	_____Sleep Disorders			_____Other (specify):_____			

Other Diseases or Details of Above:_____

Food Allergies/Dietary Modifications:_____

Operations, Major Injuries or Hospitalization (dates)_____

Items your child may need help with while at camp: Fear of Dark____ Sleepwalking____ Bedwetting_____ Other:_____

Any additional information about the participants behavior, special needs, disabilities (physical, mental, learning, developmental), or physical, emotional, or mental health about which the camp should be aware. Include recent trauma or life changes.

For Females: Has she menstruated?_____ If not, has she been told about it?_____ If she has started, is her menstrual history normal?_____ Special Considerations:_____

MEDICATION: List all medications camper has taken in the past six months and all medications that will accompany him/her to camp (include over the counter medications and vitamins). Include additional page if necessary.

Medications taken in the past six months:

Name:_____ Reason:_____

Name:_____ Reason:_____

Medications to be taken at camp:

Name:_____ Reason:_____

Dosage & Frequency_____

Special Instructions_____

Name:_____ Reason:_____

Dosage & Frequency_____

Special Instructions_____

****OPTIONAL** HEALTH CARE RECCOMENDATIONS BY LICENCED MEDICAL PERSONNEL **OPTIONAL****

I have examined the above named camp applicant within the past two years. Date Examined:_____

In my opinion, the above named applicant _____is _____is not able to participate in an active camp program.

The applicant is under care of a physician for the following condition(s)_____

Current Treatments_____

Recommendations & Restrictions while at camp_____

SIGNATURE OF LICENSED MEDICAL PERSONNEL_____ Date_____

Printed Name of L.M.P._____Phone (_____)_____