

# 2012 Staff Health Form

**IMPORTANT: HEALTH FORM MUST BE SIGNED AND MAILED IN PRIOR TO PRE-CAMP**

The Health Form will be given to the camp Nurse during your stay – please ensure it is filled out completely and accurately.

## STAFF MEMBER'S INFORMATION: *(print clearly)*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_  
 Birthdate: day: \_\_\_\_\_ / month: \_\_\_\_\_ / year: \_\_\_\_\_ Age on July 1<sup>st</sup>, 2012: \_\_\_\_\_ Gender:  Male  Female  
 Home Address: \_\_\_\_\_  
 City/Town: \_\_\_\_\_ Province/State: \_\_\_\_\_  
 Country: \_\_\_\_\_ Postal Code/Zip: \_\_\_\_\_ Home Phone# (\_\_\_\_\_) \_\_\_\_\_

## PARENTS / GUARDIANS & EMERGENCY CONTACTS: *(print clearly)* *(attach separate sheet of paper if necessary)*

**★★★ List in order who should be contacted in case of emergency – be sure to include parents/guardians: ★★★**

<b>1<sup>st</sup> Contact:</b> <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. First & Last Name: _____ Relationship: _____ Home Phone: (_____) _____ Work #: (_____) _____ Cell/Pager: (_____) _____ Cottage#: (_____) _____	<b>2<sup>nd</sup> Contact:</b> <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. First & Last Name: _____ Relationship: _____ Home Phone: (_____) _____ Work #: (_____) _____ Cell/Pager: (_____) _____ Cottage#: (_____) _____	<b>3<sup>rd</sup> Contact:</b> <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Miss <input type="checkbox"/> Dr. First & Last Name: _____ Relationship: _____ Home Phone: (_____) _____ Work #: (_____) _____ Cell/Pager: (_____) _____ Cottage#: (_____) _____
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**If this staff member is under 18**, and there is a  separation,  divorce, or  step-parent, who has Custody and is Legally Responsible for this person:  Both Parents  Mother  Father  Grandparents  Guardian  Other: \_\_\_\_\_

**Health Card #:** \_\_\_\_\_ **Version Code:** \_\_\_\_\_  
*Out-of-Canada staff: indicate any medical plan, numbers & billing address, (attach separate piece of paper if necessary)*  
**Family Doctor:** \_\_\_\_\_ **Phone:** (\_\_\_\_\_) \_\_\_\_\_  
**Address:** \_\_\_\_\_ **City:** \_\_\_\_\_  
**Permission** for our Camp Nurse/Doctor to contact your Family Doctor if necessary?  Yes  No  
**Immunization Dates:** Tetanus: \_\_\_\_\_ Polio: \_\_\_\_\_  
 Diphtheria: \_\_\_\_\_ Hepatitis B: \_\_\_\_\_  
 Pertussis: \_\_\_\_\_ Meningitis: \_\_\_\_\_

**All staff** are required to submit a photo for safety reasons.

**Attach current wallet-sized photo**

Be sure to print full name on back of photo.

**1. DIETARY INFO:**  Vegetarian  Vegan  Lactose Intolerant  Gluten Free  Other: \_\_\_\_\_

**2. ALLERGIES:** Be specific, attach separate page if necessary. If staff member uses an epipen, they must bring it to camp.  
**\*\* If you have an anaphylaxis allergy you MUST fill out an "ANAPHYLAXIS EMERGENCY PLAN FORM" in addition to this form.** (see our website page: <http://www.campkawartha.ca/summer-camp/employment.php>)

**★ Please note, we do NOT use or allow foods/snacks that contain nuts or traces of nuts. ★**

Indicate Type: Drug, Food, Environmental, Insect, Other	Allergen	Type & Severity of Reaction (Indicate if life-threatening)	Management / Treatment / Medication	Date of Last Reaction

**3. ASTHMA:** Does this staff suffer from asthma?  No  Yes If yes, indicate severity?  Mild  Moderate  Severe

What are the triggers for these attacks? \_\_\_\_\_

## 4. MEDICATIONS:

Is this staff member currently on any medication (prescription or homeopathic)? If so, what? \_\_\_\_\_

How and when is this medication administered? \_\_\_\_\_

## 2012 Staff Health Form (continued)

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

### MEDICATIONS:

**Medications must be left with the health care staff while at camp (exceptions may be made after consultation with the Health Care Co-ordinator). Prescription medications must be in their original container and must be labeled with the doctor's name, staff member's name, dosage, schedule, route and date. Over the counter medications must be in the original container with proper labeling.**

### 5. OVER-THE-COUNTER MEDICINE:

Check (✓) if you approve the use of the following over-the-counter medicine that the camp has, if deemed necessary by the nurse?

Tylenol (Acetaminophen),  Advil (Ibuprofen),  Gravol,  cough medicine,  cold medications,  antihistamines

If NO, what would be an appropriate alternative? \_\_\_\_\_

**6. ACTIVITIES:** Camp Kawartha is located on a rugged, wooded site. Most of the activities take place outdoors.

Does this staff member have any physical, developmental, behavioral, or emotional condition that may affect his/her ability to participate in camp activities?  No  Yes - If yes, give details: \_\_\_\_\_

**\*\*\*You will be responsible for any charges/expenses incurred to Camp Kawartha if you need to be evacuated from an off-site trip, due to a medical or health condition, that was not disclosed prior to your attendance.**

**7. HEALTH HISTORY:** Check (✓) if camper has had, or double-check (✓✓) if camper currently subject to any of the following:

<input type="checkbox"/> chicken pox	<input type="checkbox"/> epilepsy / seizures	<input type="checkbox"/> frequent stomach aches	<input type="checkbox"/> ear trouble	<input type="checkbox"/> sleepwalking
<input type="checkbox"/> measles	<input type="checkbox"/> fainting / dizziness	<input type="checkbox"/> frequent headaches	<input type="checkbox"/> eye trouble	<input type="checkbox"/> other:
<input type="checkbox"/> mumps	<input type="checkbox"/> appendicitis	<input type="checkbox"/> migraines	<input type="checkbox"/> nosebleeds	
<input type="checkbox"/> rheumatic fever	<input type="checkbox"/> tonsillitis	<input type="checkbox"/> sprains or strains	<input type="checkbox"/> toothaches	
<input type="checkbox"/> whooping cough	<input type="checkbox"/> heart condition	<input type="checkbox"/> fractures	<input type="checkbox"/> frequent colds	
<input type="checkbox"/> hepatitis	<input type="checkbox"/> mononucleosis	<input type="checkbox"/> ADD / <input type="checkbox"/> ADHD	<input type="checkbox"/> sinus trouble	

If this staff member has or had any of the above, please give details. Does it affect your ability to participate in activities? If so, how?

**8. RECENT hospitalization, operation, injury, serious illness, or infectious disease: If so, give date and details:** \_\_\_\_\_

**10. OTHER:** please detail any other medical information of use to the Camp Physician or Camp Nurse:

### ***IMPORTANT REMINDERS - please read carefully!***

- To the best of my knowledge, I am in good health. I will notify the camp if there is any change in my health or if I am exposed to any communicable disease within 3 weeks prior to arrival at camp.
- In the case of medical emergency, I understand every effort will be made to contact my parents or guardians. In the event parents/guardians cannot be reached, I hereby give permission to the physician/nurse selected by the Camp Director to hospitalize, secure proper treatment, order injection, anaesthesia or surgery.
- I agree to reimburse the camp for any prescriptions or medical expenses incurred for this staff member.
- I will submit any changes to this health form in writing to the camp prior to arrival.
- **I will do a head lice check regularly and within 3 days before arriving at camp.**

★ Signature of Staff Member: \_\_\_\_\_ Date: \_\_\_\_\_

★ Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

(Signature of parent/guardian required if staff member is under 18 at time of signing this health form)