

CAMP HONOR STAFF MEDICAL FORM 2009

Name _____
Last First Middle Initial DOB _____

Home address _____
Street address City State Zip

Social Security number _____ Phone _____ Gender: Male Female

Spouse/Parent/Guardian _____ Phone _____

Work phone _____ Pager _____ Cell Phone _____

If above contact person not available in an emergency, notify:

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Pager _____

Insurance Information

Are you covered by medical insurance? Yes No If Yes, complete the following:

Insurance Company Name _____ Phone # _____

Name of Policy holder _____ Relationship to Participant _____

Policy # _____ Group #/ Plan # _____ Social Security # of Policy holder _____

Medical Release

In case of medical and/or surgical emergency, I authorize Camp Honor medical staff to render or to arrange for me/my child (print full name) _____ to receive any x-ray, anesthetic, medical, dental, surgical procedure, treatment and hospital care which is deemed advisable by and is to be rendered under the supervision of any physician, dentist or surgeon licensed in Arizona.

Signature _____ Date _____

If staff member is a minor: Signature of Parent or Guardian _____

—Complete this Box For Staff With Bleeding Disorders—

Type of Bleeding Disorder: VIII IX VWD Other _____ Level/Severity _____

Current Transfusion Product _____

Life-threatening Bleeds _____ Units Major Bleeds _____ Units Minor Bleeds _____ Units

Home Infusion? ___Yes ___No Describe any Target Joints _____

Inhibitor? ___No ___Yes – If yes, Last Titer and date _____ Immune Tolerance ___No ___Yes

Are you on Prophylaxis? ___No ___Yes – If Yes Dose and Schedule _____

Do you have a Central Line? ___No ___Yes – If Yes What Type? _____

Hepatitis B Antigen ___Pos ___Neg Hepatitis B Surface Antibody ___Pos ___Neg Hepatitis C ___Pos ___Neg

To Be Completed by Staff Member

HEALTH HISTORY

The following information must be completed by the staff member or parent/guardian. The intent of this information is to provide camp medical staff background information to provide appropriate care and be aware of your needs.

ALLERGIES List all known Describe reaction and previous management

Medication allergies (list)

Food allergies or Restrictions (list)

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

MEDICAL CONDITIONS

HIV ___ Heart Disease ___ Kidney Disease ___ Asthma ___ Seizure Disorder ___ Diabetes ___ High blood Pressure ___

Please Explain Any Significant Medical History _____

MEDICATIONS

Please list All medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

This person takes NO medications on a routine basis.

Policy for Camp Staff Medications
For the safety of the campers, all camp staff staying in cabins with campers will have their personal medications (including tylenol, advil, etc.) stored in the camp infirmary. Inhalers may be kept on your person.

List Medications

Drug Name	Dose	Schedule	Reason for Taking
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATIONS

Measles vaccine Date _____	TB skin test ___Yes ___No	Was TB skin test? ___Pos ___Neg
Mumps vaccine Date _____	Hepatitis A ___Yes ___No	Hepatitis B ___Yes ___No
Rubella vaccine Date _____	Date of last Tetanus shot _____	

**CAMP HONOR
STAFF MEDICAL FORM 2009**

Name _____

I have examined the above participant. Date of last examination _____

Weight _____ BP _____ / _____ Pulse _____

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

MEDICAL CONDITIONS

Heart Disease ____ Kidney Disease ____ Asthma ____ Seizures ____ Hemophilia or VWD ____ HIV ____ Diabetes ____

Other _____

Any significant illnesses or injuries _____

PHYSICAL EXAM

<u>GENERAL</u>	<u>NORMAL</u>	<u>ABNORMAL</u>	<u>EXPLAIN ABNORMALITIES</u>
Head & Neck	_____	_____	_____
Eyes & Ears	_____	_____	_____
Nose & Throat	_____	_____	_____
Chest	_____	_____	_____
Heart	_____	_____	_____
Abdomen	_____	_____	_____
Skin	_____	_____	_____
Lymphatic	_____	_____	_____
Neurological	_____	_____	_____
Joints/Muscles	_____	_____	_____

Assessment and/or any other significant medical history:

Limitations

Activity restrictions _____

Diet restrictions _____

Immunizations

Date of Last Tetanus shot _____

Signature of Physician _____ Date _____ Phone _____ 24 Hour Phone _____

Printed Name of Physician _____ Mailing Address _____