

STAFF HEALTH HISTORY FORM

BECAUSE WE WANT TO SUPPORT YOUR ABILITY TO DO YOUR JOB WELL, PLEASE COMPLETE THIS FORM ACCURATELY AND COMPLETELY

Please Print All Information

<p><i>Please return Completed Form by May 1st to:</i></p> <p>Camp Agawam 54 Agawam Road Raymond, ME 04071</p> <p>Questions? Please call: September 1st to May 31st (207) 892-1200 June 1st to August 31st (207) 627-4780</p>	<p>Dates will attend camp: ____/____/____ to ____/____/____ Date of Birth: ____/____/____ <small style="display: flex; justify-content: space-around; font-size: 8px;">Month Day Year Month Day Year Month Day Year</small></p> <p>Staff Name: _____ <input type="checkbox"/> M or <input type="checkbox"/> F <small style="display: flex; justify-content: space-between; font-size: 8px;">(First Name) (Middle Name) (Last Name)</small></p> <p>Permanent Address: _____</p> <p>City: _____ State: _____ Zip: _____ Country: _____</p> <p>Phone: (____) _____ Cell Phone: (____) _____</p> <p>Email: _____</p> <p>~~~~~</p> <p>Your Job Title: _____ Contract Start Date: ____/____/____ <small style="display: flex; justify-content: flex-end; font-size: 8px;">Month Day Year</small></p> <p>International Staff: rate your ability to speak English: 0 1 2 3 4 5 Contract End Date: ____/____/____ <small style="display: flex; justify-content: space-around; font-size: 8px;">None Good Excellent Month Day Year</small></p>
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- Ⓢ Return this form to our Camp Office at least four weeks before you arrive. People hired within four weeks of their start date should not send this form; please bring it with you and give it to the Health Center staff at Camp.
- Ⓢ Keep a copy of the completed form for your records; note changes that occur and inform the healthcare provider of these changes.
- Ⓢ Notify the Camp Director if you are exposed to a communicable disease within three weeks of beginning your job.
- Ⓢ Camp expects that you arrive in good health and capable of doing the job for which you were hired.
- Ⓢ Information on this form is available to Health Center staff and your work supervisor(s).

Allergies:

- No known allergies.
- Known allergies:
- Food: 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: _____
- Medicine: I am allergic to this medication/s: _____ This causes anaphylaxis? Yes No
Describe what happens if you ingest this medication and how the reaction is managed: _____
- The environment (insect stings, hay fever, etc.) _____ This causes anaphylaxis? Yes No
Describe what happens if you come in contact with this aspect of the environment and how the reaction is managed: _____
- Other: I am allergic to these substances: _____ This causes anaphylaxis? Yes No
Describe what happens if you come in contact with this substance and how the reaction is managed: _____

Diet & Nutrition:

Our expectation is that staff set an example for campers by eating the provided menu. We can work effectively with some medically prescribed diets, but cannot cater to individual food preferences. There are times when you might need to simply not eat a served item.

- I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.
- I am a vegetarian of this type: Semi-vegetarian (no pork or beef) Vegan (no meats, eggs or dairy) Pesco (no pork, beef or chicken)
 Lacto-ovo (no beef, pork, chicken, seafood, or fish)
- I am lactose-intolerant. *Be prepared to manage your intolerance using products such as Lactaid or food avoidance.*
- I avoid _____ because of religious beliefs (*Camp kitchens are not kosher*).
- I respond with an anaphylactic reaction when I eat this food: _____

Chronic Concerns:

*Check all that pertain to you and provide information about supportive health care. *Asthma or Diabetes? Complete additional form available.*

- I have no chronic health concerns.
 - I have the following chronic health concern(s):
 Asthma* Headaches/Migraines Sleep problem Diabetes* Difficult breathing Dysmenorrhea Fainting
 Surgery history Back pain or injury Knee or ankle weakness Seizure disorder: _____
 Other: _____
- Provide information about supportive healthcare needed for each checked item: _____

STAFF HEALTH HISTORY FORM

Developed and reviewed by: American Camp Association, American Academy of Pediatrics Council on School Health, & Association of Camp Nurses

Staff: _____
 (First Name) (Middle Name) (Last Name)

Birth Date: ____/____/____
 Month Day Year

Immunization History: Provide the month and year for immunizations. Starred (*) immunizations must be current. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year	Results: Positive/Negative
Diphtheria, Tetanus, Pertussis * (e.g. DTaP, Tdap-Hib, DTaP-HebB-IPV, DT, Tdap, Td)							
Tetanus booster * (e.g. dT or Tdap)							
Mumps, measles, rubella * (e.g. MMR, MMRV)							
Polio * (e.g. IPV, DTaP-HebB-IPV)							
Haemophilus influenzae type B (e.g. Hib, Hib-HepB, DTaP-Hib)							
Pneumococcal (e.g. PCV, PCV, conjugate, PPV, polysaccharide)							
Hepatitis B (e.g. HepB, Hib-HepB, DTaP-Hib)							
Hepatitis A or C (e.g. Hep A, HepC)							
Varicella (e.g. Var, MMRV) (chicken pox)							
<input type="checkbox"/> Had chicken pox Date: _____							
Meningococcal meningitis (e.g. MCV4)							
Rotavirus (e.g. Rv) Never Given after 32 weeks of age							
Human Papillomavirus (e.g. HPV)							
Influenza (e.g. TIV, inactivated; LAV, live attenuated)							
Other:							

Tuberculosis (TB) test: _____ Date: _____ Negative Positive

If you have not been fully immunized, please sign the following statement: I understand and accept the risks to myself (my child) from not being fully immunized.

Signature: _____ Date: ____/____/____ Signature of Parent/Guardian (if under 18 yrs.): _____

Medication: I will not take any daily medications while attending camp.

I will take the following daily medication(s) while at camp:
 "Medication" is any substance a person takes to maintain and/or improve his health. This includes vitamins & natural remedies. Prescription Meds **ARE REQUIRED to be in original pharmacy containers with labels** which show the name and how the medication should be given (International staff, please provide English translation). **Please bring enough medication to last the entire length of camp or bring your written prescription to order a refill.**

Name of Medication	Date Started?	Reason for Taking It	When it is given	Amount or dose given	How it is given
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		
			<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner <input type="checkbox"/> Bedtime <input type="checkbox"/> Other time: _____		

Emergency Contact: Whom do you want us to contact in an emergency?
 First Contact: _____ Phone: (____) _____
 Relationship to You: _____
 Alternate Contact: _____ Phone: (____) _____
 Relationship to You: _____

Paying for Health Care:

- There is usually no charge for health care provided by the camp's Health Center staff.
- Staff Members are financially responsible for health care provided by out-of-camp providers.
- If you will be using personal insurance while working at camp, it is your responsibility to know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

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Staff: _____
(First Name) (Middle Name) (Last Name)

Birth Date: ____/____/____
Month Day Year

General Health History: Check "Yes" or "No" for each statement (please explain "Yes" answers on a separate sheet and attach it to this form, noting the number of the question/s):

Have/do/can you:

1. Ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Wear glasses or contacts or use protective eye wear?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have an uncorrected vision (sight) problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Ever passed out during or after exercise/physical exertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Ever had a stinger, burner, or pinched nerve?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Ever been dizzy during or after exercise/physical exertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Ever had heat or muscle cramps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Ever had chest pain during or after exercise/physical exertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Been dizzy or passed out in the heat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Tire more quickly than your friends during exercise/physical exertion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	20. Had chicken pox or are you immunized for chicken pox?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Ever had high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Had mononucleosis in the past nine months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Ever been told that you had a heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Have an uncorrected hearing problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Ever had racing of your heart or skipped heartbeats?	<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Have skin problems (itching, rashes, acne)?	
10. Do you have any piercings? If so, where?	<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of your body areas? If yes, where?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Eyebrow <input type="checkbox"/> Ears <input type="checkbox"/> Nose		<input type="checkbox"/> Neck <input type="checkbox"/> Chest <input type="checkbox"/> Forearm <input type="checkbox"/> Shin/calf <input type="checkbox"/> Back	
<input type="checkbox"/> Tongue <input type="checkbox"/> Belly Button <input type="checkbox"/> Nipple		<input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Ankle <input type="checkbox"/> Elbow <input type="checkbox"/> Knee	
<input type="checkbox"/> Other: _____		<input type="checkbox"/> Hip <input type="checkbox"/> Foot <input type="checkbox"/> Head <input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh	
11. Smoke and/or use other tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No	25. Been in countries other than the United States in the past nine months? (Please give details below)	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Any problems with your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	26. For travel outside the country, please name the countries visited and dates of travel:	
Ever had a seizure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Country: _____ Dates: ____/____/____ to ____/____/____	
13. Lift and carry 30 pounds (14 kilograms) at least ten times without assistance or discomfort?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Country: _____ Dates: ____/____/____ to ____/____/____	
14. Ever been knocked out, fainted, or become unconscious?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Country: _____ Dates: ____/____/____ to ____/____/____	
		Country: _____ Dates: ____/____/____ to ____/____/____	
		27. For women: Do you have a menstrual problem (pain, irregularity, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Mental, Emotional, and Social Health: Check "Yes" or "No" for each statement:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder AD/HD?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you have an eating disorder that will impact your work? Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have a learning disability that will impact your work? Type: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have an emotional health concern that will impact your work?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please explain "Yes" answers on a separate sheet of paper and attach it to this form, noting the number of the questions (the camp may contact you for additional information):

- (a) Describes the concern and your management plan for addressing it while working at camp; and
- (b) Describes the support needed from your work supervisor to compliment your plan. Refer to the Essential Functions of your job, outlined on your Application, your Job Description and in the Personnel Policies and Procedures, if there are questions.

Health Care Providers:

Name of primary doctor(s): _____ Phone: (____) _____

Name of your dentist(s): _____ Phone: (____) _____

Name of orthodontist(s): _____ Phone: (____) _____

What Have We Forgotten to Ask? Please provide in the space below any additional information about the camper's health that you think important or that may affect the camper's ability to fully participate in the camp program (attach additional information if needed):

Authorization for Health Care:

This health history is correct insofar as I know. 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 Health Care staff in providing care to me and may be reviewed by my work supervisor.

Signature of Staff Person: _____ Date: _____

Signature of Parent (if under 18 yrs.): _____ Date: _____

