

CAMP-of-the-WOODS Health Form

The purpose of having this health form is to assist CAMP-of-the-WOODS Health Care Staff in identifying appropriate care. This health form is required in order to work at Camp. Health forms from last year are **not valid** for this year.

STAFF INFORMATION (Please print clearly)

Name (Last) _____ (First) _____ (M.I.) _____ Birth Date ___/___/___ Age at camp _____

Current Address _____ (City) _____ (State) _____ (Zip) _____ Phone(____) _____

Permanent Address _____ (City) _____ (State) _____ (Zip) _____ Phone(____) _____

Social Security Number _____ Gender: Female Male

PARENT/GUARDIAN CONTACT

Name _____ Relationship _____

Phone (____) _____ Cell Phone (____) _____

Address _____ (City) _____ (State) _____ (Zip) _____ Phone(____) _____

EMERGENCY CONTACT (to be used if parent cannot be reached)

Name _____ Relationship _____

Phone (____) _____ Cell Phone (____) _____

Address _____ (City) _____ (State) _____ (Zip) _____ Phone(____) _____

Physician's Name: _____ Phone(____) _____

INSURANCE INFORMATION

Is the staffer covered by family medical/hospital insurance? Yes No

If so, indicate Insurance Company: _____

Group # _____ Prescription Plan # _____

Name of insured _____ Relationship to Staffer _____

PLEASE INCLUDE A PHOTOCOPY OF HEALTH INSURANCE CARD TO BE USED IN THE EVENT THAT MEDICAL TREATMENT OR PRESCRIPTION IS REQUIRED.

Authorization and Permission to Provide Necessary Treatment or Emergency Care

(MUST be 18 or older to sign this section. If not 18, please have parent/guardian sign section below)

This health history is correct and complete as far as I know and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the medical personnel selected by CAMP-of-the-WOODS to order X-rays, routine tests, and/or seek emergency medical treatment. I agree to the release of any records necessary for insurance purposes and give my permission to arrange necessary related transportation for me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Camp Nurse and/or his/her Assistant(s) to secure and administer treatment, including hospitalization, for the person named above. The completed form may be photocopied for trips out of camp.

Signature of Staffer _____ Date _____

Signature of Parent/Guardian _____ Date _____

ALLERGIES (List all known)

		Describe reaction and management of the reaction
Medication	1.	1.
	2.	2.
Food	1.	1.
	2.	2.
Other		
Other		

MEDICATIONS (List all currently taking)

Medication	Dosage	Specific times taken each day	Reason for taking
1.			
2.			
3.			
4.			

Explain any restrictions to activity

General Questions (Explain "yes" answers below)

Has/does the staffer:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Ever had problems with joints (ex. knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have an orthodontic appliance being brought to camp?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have any skin problems (ex. itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or protective eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had mononucleosis in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Had problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. Have problems sleeping walking?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever had measles, chicken pox, german measles, or mumps?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain any "yes" answers, noting the number of the question.

IMMUNIZATION HISTORY:

DPT or DR or TD	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Polio	Date: _____	Date: _____	Date: _____	Date: _____	Date: _____
Tetanus	Date: _____				
Measles	Date: _____				
Mumps	Date: _____				
Rubella	Date: _____				
Chicken pox/varicella	Date: _____				
Haemophilus influenza B	Date: _____				
Hepatitis B	Date: _____				
Hepatitis A	Date: _____				
TB Mantous Test	Date of last Test: _____	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative		

Use the space below to provide any additional information about the participant's behavior of which the camp should be aware.

Physical Examination - To be filled out by Physician

Staffer Name _____ Date of Birth ____/____/____
Last *First*

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

B/P _____ Weight _____ Height _____ Urine _____ Vision _____

Eyes: _____	Posture/Spine: _____
Ears: _____	Skin: _____
Nose: _____	Hernia: _____
Throat: _____	Teeth: _____
Heart: _____	Abdomen: _____
Lungs: _____	

RECOMMENDATIONS WHILE AT CAMP:

Special Diet: _____

Medications:

- This person takes NO medications on a routine basis.

- This person takes medications as follows:
 (Any medication prescriptions must arrive in the original containers with the pharmacy label attached)

Medication	Dosage	Specific times taken each day	Reason for taking
1.			
2.			
3.			

Activity Restrictions/Limitations _____

Additional Information for Health Care Staff: _____

I have examined the patient herein described and have reviewed the health history. It is my opinion that this child is physically able to engage in the regular camp activities, except as noted.

Physician's Signature _____ **Date:** _____

Please Print Name _____ **Phone Number** _____

Address _____

INSURANCE INFORMATION/RELEASE FORM

NAME: _____ M F Date of Birth: _____
Last First M.I.

ADDRESS: _____ Phone: _____
Number & street City State Zip

LOCAL ADDRESS: (if different) _____

LOCAL PHONE: _____ SOCIAL SECURITY #: _____ MARITAL STATUS: _____

EMPLOYER: CAMP-OF-THE-WOODS / SPECULATOR, NY 12164 PHONE: (518) 548-4311

OCCUPATION: SUMMER STAFF

Person to contact in Case of Emergency: _____

Relationship: _____ Home Phone # _____

Pharmacy you use: _____

PERSON FINANCIALLY RESPONSIBLE IF OTHER THAN PATIENT:

NAME: _____ Relationship to Patient: _____ DOB: _____ SS#: _____

ADDRESS: _____ Phone: _____

EMPLOYER: _____ OCCUPATION: _____ Work Phone: _____

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

Primary Insurance: _____ ID # _____ GROUP # _____

Secondary Insurance: _____ ID # _____ GROUP # _____

*****MAKE COPIES FRONT AND BACK OF ALL INSURANCE CARDS, INCLUDING DRUG CARDS AND***
ATTACH COPIES TO THIS FORM**

**I AUTHORIZE THE RELEASE OF THE FOLLOWING TYPES OF INFORMATION
(From Nathan Littauer Primary Care Center) TO THE FOLLOWING PEOPLE:**

_____	ID _____	appt. _____	billing _____	medical _____
_____	ID _____	appt. _____	billing _____	medical _____
_____	ID _____	appt. _____	billing _____	medical _____

Assignment of Benefits/Release of Records

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance and any other health plans to Nathan Littauer Primary Care Center. I understand that I am financially responsible for all changes whether or not paid by said insurance. I hereby authorize said assignee to release any information necessary to secure said benefits.

I hereby authorize Nathan Littauer Primary Care Center to release any information including the diagnosis and records of any treatment rendered to myself, or in my son/daughter, to my referring physician or to any other physician from whom I seek medical treatment. Additionally, I hereby authorize any other physicians who have rendered services to me to release to Nathan Littauer Primary Care Center such information as they shall request to assist in my medical treatment.

Signature _____ Date _____

(Must be signed by parent/guardian if under 18 years of age)

Assignment for Treatment

I hereby authorize the medical care providers at Nathan Littauer Primary Care Center to render medical care to myself or the above named person (legal Guardianship required). I understand that such medical care may include history taking, diagnostic testing and administration of medication. I understand that at any time I may discontinue treatment or a part thereof. Invasive procedures will require a separate and distinct authorization for treatment which includes informed consent of such procedure.

Signature _____ Date _____

(Must be signed by parent/guardian if under 18 years of age)