STAFF HEALTH FORM

Please return fully completed form (both sides) no later than June 1st to:
PO Box 176, Ringwood, New Jersey 07456 • (973) 831-9000 office • (973) 831-9174 fax

Each applicant MUST have a fully completed medical form for the CURRENT CAMP YEAR or will not be admitted to camp.

THIS SIDE TO BE COMPLETED AND SIGNED BY APPLICANT OR PARENT/GUARDIAN IF UNDER 18. Please print.

Name _____ Birth Date _____ Age at Camp _____ ❑ M ❑ F
Last First M.I.

Siblings or Children at Camp _____

Parent/Guardian (or Spouse) _____ Home Phone ( ) _____

Home Address _____ City _____ State _____ Zip _____

Bus. Phone ( ) _____ Cell Phone ( ) _____ Fax ( ) _____

Second Parent/Guardian _____ Home Phone ( ) _____

Home Address _____ City _____ State _____ Zip _____

Bus. Phone ( ) _____ Cell Phone ( ) _____ Fax ( ) _____

IF PARENT OR SPOUSE IS NOT AVAILABLE IN AN EMERGENCY, PLEASE NOTIFY:

Name _____ Relationship _____

Home Phone ( ) _____ Cell Phone ( ) _____

Name of Primary Physician _____ Phone ( ) _____

Health Insurance Carrier _____ Policy # _____ Group # _____

GENERAL QUESTIONS: Please explain "yes" answers below.

Has/does the applicant:	Yes	No
1. Had any recent injury, illness or infectious disease?	❑	❑
2. Have a chronic or recurring illness / condition?	❑	❑
3. Have chronic lung condition / asthma?	❑	❑
4. Ever been hospitalized or had surgery?	❑	❑
5. Ever had a head injury or lost consciousness?	❑	❑
6. Have frequent headaches?	❑	❑
7. Ever had seizures?	❑	❑
8. Wear glasses, contacts or protective eyewear?	❑	❑
9. Have an orthodontic appliance being brought to camp?	❑	❑
10. Have diabetes?	❑	❑
If yes, health care provider orders signed by a doctor must be submitted.		
11. Ever had frequent ear infections?	❑	❑
12. Ever had chest pain during or after exercise?	❑	❑
13. Ever been dizzy/passed out during or after exercise?	❑	❑
14. Ever had high blood pressure?	❑	❑
15. Ever been diagnosed with a heart murmur?	❑	❑
16. Ever had back problems?	❑	❑
17. Ever had problems with joints (e.g., knees, ankles)?	❑	❑
18. Have any skin problems (e.g., itching, rash, acne)?	❑	❑
19. Had problems with diarrhea/constipation?	❑	❑
20. If female, have an abnormal menstrual history?	❑	❑
21. Ever had an eating disorder?	❑	❑
22. Ever seek professional help for emotional difficulty?	❑	❑
23. Ever have issues with bleeding or clotting?	❑	❑
24. Have HIV?	❑	❑
25. Have or had Mono in the last 12 months?	❑	❑
26. Have any immunodeficiency?	❑	❑
27. Ever receive special services during the year?	❑	❑

Please explain any YES answers! _____

IMPORTANT: THIS AREA MUST BE COMPLETED! I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order X-Rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for the applicant. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

I ❑ do ❑ do not give permission for the camp nurse to administer Tylenol® (acetaminophen) if necessary.

I ❑ do ❑ do not give permission for the camp nurse to administer Advil® (ibuprofen) if necessary.

Nursing staff may not administer ANY other medications without a doctor's order including over-the-counter items such as ear drops, cortisone cream, etc.

Spring Lake Day Camp is licensed by the New Jersey State Department of Health, and is inspected annually.

Name of applicant (name of parent/guardian if applicant is under 18) *(Print)* _____

Signature of applicant (signature of parent/guardian if applicant is under 18) _____

Date _____

REVERSE SIDE OF THIS FORM MUST BE COMPLETED BY PHYSICIAN

THIS SIDE TO BE COMPLETED BY PHYSICIAN: Please print legibly or type

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Applicant's Name _____ **Birth Date** _____

I examined this individual on _____ . (ACA accreditation requirements specify exams within 12 months of camp attendance.)

BP_____ Weight_____ Height_____ In my opinion, the above applicant ❑ is ❑ is not able to participate in an active camp program.

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

If applicant has diabetes, health care provider orders for diabetes maintenance must be submitted.

IMMUNIZATIONS (Please indicate month/year)

DPT						
TD						
MMR						
HiB						
Hepatitis B						
Varicella (chicken Pox)						
Polio						

Has the applicant had any of the following:

❑ Measles ❑ Chicken Pox ❑ Mumps
❑ German Measles ❑ Hepatitis A ❑ Hepatitis B
❑ Hepatitis C ❑ Other _____

Allergies: ❑ None ❑ Yes (indicate below)

❑ Asthma ❑ Hay Fever ❑ Penicillin
❑ Dairy ❑ Soy ❑ Wheat
❑ Peanuts ❑ Tree Nuts ❑ Poison Ivy
❑ Insect Stings ❑ Bee Stings ❑ Other _____

TB Mantoux Test: Date of Last Test: _____ Result: ❑ Positive ❑ Negative

MANDATORY: Date of Last Tetanus Booster (Give month and year)_____

To the best of my knowledge, there ❑ Is ❑ Is not a medical contraindication to administering acetaminophen (Tylenol® and Ibuprofin)

Describe any current physical, mental or psychological conditions requiring medication, treatment or special restrictions or conditions while at camp. _____

_____

_____

Describe any camp activities from which applicant is exempted. _____

_____

_____

_____

Describe any current treatments to be continued at camp including bronchial inhaler, bee sting kit, epi-pen or other health related device.

_____

_____

List all current medications to be administered at camp; prescribed or over-the-counter including name, dosage, route and frequency.

_____

_____

Describe any dietary restrictions. _____

_____

List all known allergies. _____

_____

Licensed Physician's Name (Please print or stamp below): _____ **Signature** _____

Address _____ Phone ( )_____

Date of completion of this form: _____ Completed by _____