Maplewood Staff Health Form

Developed by the American Camping Association, Inc., in consultation with the American Medical Association of Pediatrics

This side to be filled in by parent/guardian of minor or by adult staff members.

Name _____ Birth Date _____ Sex _____ Age _____

Parent or Guardian (or Spouse) _____ Phone _____

Home Address _____

Business Address _____ Phone _____

Second Parent or Emergency Contact _____ Phone _____

Home Address _____

Business Address _____ Phone _____

If not available in an emergency, notify:

Name _____ Phone _____

Address _____

Health History : (Check – give approximate dates)

		Diseases		Allergies	
Frequents Ear Infections	_____	Chicken Pox	_____	Asthma	_____
Heart Defect/Disease	_____	Measles	_____	Hay Fever	_____
Convulsions	_____	German Measles	_____	Ivy Poisoning	_____
Diabetes	_____	Mumps	_____	Insect Stings	_____
Bleeding/Clotting Disorders	_____			Penicillin	_____
Hypertensions	_____			Other Drugs	_____
Mononucleosis	_____				

Operations or serious injuries (dates) : _____

Disability or chronic or recurring illness: _____

Any specific activities to be encouraged or limited by physician's advice: _____

_____

Dietary modifications: _____

Current Medication (send with instructions): _____

Other diseases or details of above: _____

Name of dentist/orthodontist: _____

Name of family physician: _____

Do you carry family medical/hospital insurance? ____ If so, indicate:

Carrier: _____ Policy or Group #: _____

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Immunization History:

Required immunizations must be determined locally. Please record the date (month& year) of basic immunizations and most recent booster doses.

Vaccines	Year of Basic Immunizations	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT Tetanus or	1 2 3	1 2
Tetanus Diphtheria TD or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles (Hard Measles, Red Measles, Rubeola)		
Mumps		
Rubella (German Measles, 3-day measles		
Other		
Tuberculin Test Given _____		
Haemophilus Influenza B (HIB)		

Health Care Recommendations by Licensed Physician:

I have examined the above camp applicant within the past year. Date examined: _____

In my opinion, the applicant's condition does ___ does not ___ preclude his\her participation in an active program.

Height _____ Weight _____ Blood Pressure _____

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

_____

Current treatment (include current medications): _____

_____ _____

Explanation of any reported loss of consciousness, convulsion or concussion: _____

_____

Does applicant have epilepsy? Yes _____ No _____ Does applicant have diabetes? Yes _____ No _____

Recommendations and Restrictions:

Any treatment to be continued at camp? _____

Any medications to be administered at camp? _____

Any medically prescribed meal plan or dietary restrictions? _____

_____

Licensed Physician's Signature _____

Address _____ Phone # _____

Date of Examination _____ Completed by _____