

SWIFT NATURE CAMP

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SNC.Camp

Health History Form

As a counselor or support staff member you are required to bring this health form with you to camp. This health form does not affect your camp's decision to hire you, however, falsifying or failing to disclose *information about your health* may result in dismissal. If you have any questions or concerns about completing this form, contact a Director. If additional space is needed, please attach a separate sheet.

PERSONAL INFORMATION

Name _____ Birth Date _____ Sex: Male Female

Home Address _____
Last First

Home Phone # _____ School Phone # _____
Number & Street City St. Zip Code

Emergency Contact _____ Relationship _____

Emergency Contact Home Phone # _____ Work Phone # _____

Alternate contact in case of emergency:
 Name _____ Phone # _____

HEALTH HISTORY-APPLICANT COMPLETE THIS SECTION

Check all that apply and give approximate date of illness

	Date
<input type="checkbox"/> Frequent ear infections	_____
<input type="checkbox"/> Heart defect/disease	_____
<input type="checkbox"/> Convulsions	_____
<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Bleeding disorders	_____
<input type="checkbox"/> Hypertension	_____
<input type="checkbox"/> Mononucleosis	_____
<input type="checkbox"/> Sinus trouble	_____
<input type="checkbox"/> Migraine headaches	_____

Allergies

	Date
<input type="checkbox"/> Poison Ivy/oak	_____
<input type="checkbox"/> Insect stings	_____
<input type="checkbox"/> Hay fever	_____
<input type="checkbox"/> Penicillin	_____
<input type="checkbox"/> Other drugs	_____
<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Food (specify below)	_____

Diseases

	Date
<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Chicken Pox	_____
<input type="checkbox"/> German Measles	_____
<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Hepatitis	_____
<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Bronchitis	_____

List surgeries or major illnesses you have had in the last 18 months (include dates):

List any chronic health concerns which affect your ability to work:

What can your employer do to facilitate your performance?

Have you ever been under a professional's care for emotional, psychological or learning difficulties? Yes No If yes, please describe _____

Do you smoke? Yes No

Can you do the following without difficulty?

Push	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pull	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Walk	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Run	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bend	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lift	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered no to any of the above activities, please explain:

Insurance Information

Is the staff member covered by medical/hospital insurance?
 Yes No

If so, indicate carrier or plan name

 # _____

Carrier Address: _____

This information is valid with regard to my current health status. I understand and agree that if this information is incorrect or I am not able to follow the health guidelines set by my camp, I risk dismissal from Swift Nature Camp. If a change in my health status occurs, I agree to notify the camp in writing of that change prior to arriving.

I hereby give permission to the camp to provide, seek, and consent to routine health care, administration of prescribed medications, and emergency treatment for me as may be necessary, including, but not limited to x-rays, routine tests and treatment, and/or hospitalization

Applicant's Signature _____ Date _____

IMMUNIZATION HISTORY-MUST BE COMPLETED WITH A LICENSED PHYSICIAN

Please record the month and year of Immunizations.

Vaccines

Date of Immunization

DPT series* (Diphtheria, Pertussis, Tetanus.)	
Polio*	
MMR (Mumps, Measles, Rubella)	
Tetanus Booster*	
Typhoid	
Hepatitis B	
Tetanus	
Small Pox	
<i>H1N1 (swine flu)</i>	

*Required Immunizations

Tuberculin test given: (date) _____ Results: Positive* Negative

If your test was positive you must have a chest x-ray and submit the results with your medical form.

MEDICAL EXAMINATION-MUST BE COMPLETED BY A LICENSED PHYSICIAN

Note to examining physician: This person has applied for a program as a camp supervisor/leader of children. This program involves rigorous physical activity and long working hours. Your exam should be directed to the person's fitness to engage in such a program.

Height _____ Weight _____ Does this person wear glasses or contact lenses? _____

Please use the following code when completing your examination:

S = Satisfactory

X = Not Satisfactory

0 = Not Examined

_____ Eyes	_____ Heart	_____ Lungs
_____ Ears	_____ Spine	_____ Extremities
_____ Nose	_____ Urinalysis	_____ Blood Pressure
_____ Teeth	_____ Skin	_____ HgB
_____ Abdomen	_____ Throat	

Is this person on any medications that she/he will need to bring to camp ? (please describe) _____

Please rate the overall muscular skeletal condition of this person: _____

Back: _____

Knees: _____

Ankles: _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health which the camp should be aware of.

I have examined the above applicant and have reviewed her/his health history. It is my opinion that she/he: (circle) IS IS NOT Physically able to engage in the rigors of camp.

Licensed Examining Physician's Signature _____ Date _____

Physician's Name (please print) _____ Phone _____

Address _____
Number & Street City St Zip Code