HEALTH HISTORY AND EXAMINATION FORM FOR STAFF ATTENDING HOOSIER BURN CAMP

DUE DATE ____________

This form, except for the "Health Recommendations of Licensed Personnel," to be filled in by staff.

Name ______________________________________ Birth Date _____________________ Age at camp _____________
Last First Middle

Address ____
Street Address City State Zip

Phone # _____________________________________ Social Security # ______________ Gender: □ Male □ Female

Emergency Contact

____
Name Relationship Phone Number

____
Name Relationship Phone Number

Insurance Information

Is the participant covered by medical/hospital insurance? □ Yes □ No

If so, indicate carrier or plan name ____ Group # __________________

Carrier Address ____

Name of insured ____ Relations to participant ________________

Social Security # of policy holder or insurance ID ____

Important – These boxes must be complete for attendance *

Permission to Provide Necessary Treatment or Emergency Care:
I hereby give permission to the medical personnel selected by the HBC Health Center to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me.

Signature of staff ____ Date ______________

I also understand and agree to abide by the restrictions placed on my camp activities.

Signature of staff ____ Date ______________

* If for any religious reasons you cannot sign this, contact the HBC administration for a legal waiver which must be signed for attendance.

Health History

The following information must be filled in by the staff member. The intent of this information is to provide HBC Health Center personnel the background to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be provided to HBC Health Center upon participant's arrival in camp. Provide complete information so that the camp can be aware of your needs.

Allergies List all known including medication, food, and other. Describe reaction and management of the reaction.

_______________ ____

_______________ ____

_______________ ____

Medications Being Taken

List **ALL** medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a nonprescription drug), the name of the medication, the dosage, and the frequency of administration.

□ This person takes NO medications on a routine basis.

□ This person takes medications as follows:

Med #1 ________________________ Dosage ______________ Times taken each day ________

Reason for taking ____

Med #2 ________________________ Dosage ______________ Times taken each day ________

Reasons for taking ____

Med #3 ________________________ Dosage ______________ Times taken each day ________

Reasons for taking ____

Attach additional pages for more medications.

Restrictions
The following restrictions apply to this individual.

Dietary

□ Does not eat red meat
□ Does not eat pork
□ Does not eat eggs
□ Does not eat poultry
□ Does not eat seafood
□ Does not eat dairy products
□ Other (describe) ____

____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

____

____

General Questions (Explain "yes" answers below.) Has/does the participant:

		Yes	No
1.	Had any recent injury, illness or infectious disease?	◻	◻
2.	Have a chronic or recurring illness or condition?	◻	◻
3.	Ever been hospitalized?	◻	◻
4.	Ever had surgery?	◻	◻
5.	Have frequent headaches?	◻	◻
6.	Ever had a head injury?	◻	◻
7.	Ever been knocked unconscious?	◻	◻
8.	Wear glasses, contacts or protective eye wear?	◻	◻
9.	Ever had frequent ear infections?	◻	◻
10.	Ever pass out during or after exercise?	◻	◻
11.	Ever been dizzy during or after exercise?	◻	◻
12.	Ever had seizures?	◻	◻
13.	Ever had chest pain during or after exercise?	◻	◻
14.	Ever had high blood pressure?	◻	◻
15.	Ever been diagnosed with a heart murmur?	◻	◻
16.	Ever have back problems?	◻	◻
17.	Have an orthodontic appliance?	◻	◻
18.	Have any skin problems (e.g., itching, rash)?	◻	◻
19.	Have diabetes?	◻	◻
20.	Have asthma?	◻	◻
21.	Had mononucleosis in the past 12 months?	◻	◻
22.	Had problems with diarrhea/constipation?	◻	◻
23.	Have problems with sleepwalking?	◻	◻
24.	If female, have an abnormal menstrual history?	◻	◻
25.	Ever had an eating disorder?	◻	◻
26.	Ever had emotional difficulties for which professional help was sought?	◻	◻
27.	Ever had problems with joints (e.g., knees, ankles)?	◻	◻

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

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____

Which of the following has the participant had?

◻ Measles
◻ Chicken Pox
◻ Mumps
◻ Hepatitis

TB Mantoux Test
Date of last test ____________________
Result: ◻ Positive ◻ Negative

Give all dates of immunization for:

Vaccine: Dates:	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
DTP	______	______	______	______	______	______
TD	______	______	______	______	______	______
Tetanus	______	______	______	______	______	______
Polio	______	______	______	______	______	______
MMR	______	______				
or Measles	______	______				
or Mumps	______	______				
or Rubella	______	______				
Haemophilus Influenza B	______	______	______	______		
Hepatitis B	______	______	______			
Varicella (chicken pox)	______	______	______			
BCG	______					

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

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____

Name of physician ____ Phone ____________________

Address ____

Name of dentist ____ Phone ____________________

Address ____

Authorization: This health history is correct and complete as far as I know.

Signed ______________________________ Printed ______________________________ Date ____________

Health Care Recommendation by Licensed Medical Personnel

I have examined the above staff participant. Date of last Examination ______________________________

BP ____________ Weight ____________ Height ____________

In my opinion, the above participant ☐ is ☐ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions

____

____

Current treatment at the time of this report includes

____

____

Recommendations and Restrictions at Camp

Treatment to be continued at camp

____

____

Medications to be administered at camp (name, dosage, frequency)

____

____

Any medically-prescribed meal plan or dietary restrictions

____

____

Known Allergies

____

____

Description of any limitation or restriction on camp activities

____

____

Additional information for health care staff at the camp

____

____

Printed Name ______________________________ Title ____________________

Address ______________________________ Phone ____________

Signature of Licensed Medical Personnel ______________________________ Date ________

For Hoosier Burn Camp use only

Screening Record Date Screened ____________________ Time ____________________

Meds Received ______________________________

Updates/additions to health history noted ☐ Yes ☐ No ☐ None Required

Current health needs identified ______________________________

____

Observational notes ______________________________

Screened by ______________________________