Health History Form for Camp Staff

**Because we want to support your ability to do your job well, please complete this form accurately and completely.*

Return Completed Form to

Lutheran Camping Corporation of Central PA
PO Box 459
Arendtsville, PA 17303
(717) 677-8211
www.lutherancamping.org

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Gender: _____
Month Day Year

Permanent Address: _____

Preferred Phone #: (_____)_____ E-mail: _____

Country of Residence: _____

Your Contract Start Date: _____ End Date: _____

Your Job Title: _____

• Keep a copy of the completed form for your records; note changes that occur and inform the healthcare provider of these changes.
• Notify the camp director if you are exposed to a communicable disease within three weeks of beginning your job.
• The camp expects that you arrive in good health and capable of doing the job for which you were hired.
• Information on this form is available to Health Center staff and your work supervisor(s).

Allergies: *Check those that apply to you.*

_____ I have no known allergies.

_____ I have an allergy to this food: _____ This causes anaphylaxis? ☐ Yes ☐ No
Describe what happens if you eat this food and how the reaction is managed:

_____

_____

_____ I am allergic to this medication/s: _____This causes anaphylaxis? ☐ Yes ☐ No

_____ I am allergic to these substances: _____ This causes anaphylaxis? ☐ Yes ☐ No
Describe what happens if you eat this food and how the reaction is managed:

_____

_____

Nutrition: *Our expectation is that staff set an example for campers by ea ting the provided menu. W e can work effectively with some medically prescribed diets but cannot cater to individual food preferences. There are times when you might need to simply not eat a served item.*

_____ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.
_____ I am a vegetarian of this type: ☐ Semi-vegetarian (no pork or beef) ☐ Vegan (no meats, eggs or dairy)
☐ Pesco (no pork, beef or chicken) ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
_____ I am lactose-intolerant. *Be prepared to manage your intolerance using products such as Lactaid or food avoidance.*
_____ I avoid _____ because of religious beliefs.
_____ I respond with an anaphylactic reaction when I eat this food: _____

Chronic Concerns: *Check all that pertain to you and provide information about supportive health care.*

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s): ☐ Asthma* ☐ Headaches/Migraines ☐ Sleep problem ☐ Diabetes* ☐ Difficult breathing ☐ Dysmenorrhea ☐ Fainting ☐ Surgery history ☐ Seizure disorder: _____ ☐ Back pain or injury ☐ Knee or ankle weakness ☐ Other: _____

Provide information about supportive healthcare needed for each checked item:

_____

_____

_____

Immunization History: *Provide the month & year for immunizations. Asterisked (*) immunizations must be current.*

Immunization	Date — Month(s) & Year(s)	Immunization	Date — Month(s) & Year(s)
Tetanus Booster*	Current within 10 years:	Polio*	
Varicella* (Chicken Pox)		MMR (Mumps, Measles, Rubella)*	
Meningitis		Pneumococcal	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	DPT (diphtheria, tetanus, pertussis)*	
Hepatitis B		Hepatitis A	
Influenza			

Medication: *Bring enough medication to last or bring your written prescription to order a refill. Prescription meds MUST be in pharmacy containers with appropriate labels; other remedies must be in original container. International Staff: translate information to English.*

_____ I do not take medication on a routine basis.

_____ I take routine medication (include vitamins) as noted below.

Name of Medication	Reason for Taking It	Dose Given & When	Date Started?
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	

General Physical History

1. Have you ever been hospitalized? ☐Yes ☐No

   Have you ever had surgery? ☐Yes ☐No

2. Have you ever passed out during or after exercise/physical exertion? ☐Yes ☐No

   Have you ever been dizzy during or after exercise/physical exertion? ☐Yes ☐No

   Have you ever had chest pain during or after exercise/physical exertion? ☐Yes ☐No

   Do you tire more quickly than your friends during exercise/physical exertion? ☐Yes ☐No

   Have you ever had high blood pressure? ☐Yes ☐No

   Have you ever been told that you had a heart murmur? ☐Yes ☐No

   Have you ever had racing of your heart or skipped heartbeats? ☐Yes ☐No

3. Do you have skin problems (itching, rashes, acne)? ☐Yes ☐No

4. Have you ever been knocked out, fainted, or become unconscious? ☐Yes ☐No

   Have you ever had a seizure? ☐Yes ☐No

   Have you ever had a stinger, burner, or pinched nerve? ☐Yes ☐No

5. Have you ever had heat or muscle cramps? ☐Yes ☐No

   Have you ever been dizzy or passed out in the heat? ☐Yes ☐No

6. Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of your body areas? ☐Yes ☐No

   If so, where? ☐ Head ☐ Shoulder ☐ Thigh ☐ Neck ☐ Chest ☐ Forearm ☐ Shin/calf
   ☐ Back ☐ Wrist ☐ Hand ☐ Ankle ☐ Elbow ☐ Knee ☐ Hip ☐ Foot

   Can you lift and carry 30 pounds (14 kilograms) at least ten times without assistance or discomfort? ☐Yes ☐No

7. Have you had chicken pox or are you immunized for chicken pox? ☐Yes ☐No

8. Have you had mononucleosis in the past nine months? ☐Yes ☐No

9. Do you have an uncorrected hearing problem? ☐Yes ☐No

   Do you have an uncorrected vision (sight) problem? ☐Yes ☐No

   Do you wear glasses or contacts or use protective eye wear? ☐Yes ☐No

10. Do you smoke and/or use other tobacco products? ☐Yes ☐No

11. Do you have any piercings? ☐Yes ☐No

    If so, where? ☐ Ears ☐ Eyebrow ☐ Nose ☐ Tongue ☐ Belly Button ☐ Nipple ☐ Other: _____

12. Do you have any problems with your teeth? ☐Yes ☐No

13. Have you been in countries other than the United States in the past nine months? ☐Yes ☐No

    If yes, list the countries and the length of time spent in them.

    Country: _____ Dates: _____

    Country: _____ Dates: _____

    Country: _____ Dates: _____

14. For women: Do you have a menstrual problem (pain, irregularity, etc.)? . . . . . .☐Yes ☐No

    Explain and/or provide more detail about the General Physical Health questions to which you responded "yes."

_____

_____

_____

_____

Name of your physician: _____ Office Phone: (_____)_____

Name of your dentist/orthodontist: _____ Office Phone: (_____)_____

Mental & Emotional Health Information

A. Have you been diagnosed with attention deficit disorder (ADD) or AD/HD. . . . . ☐Yes ☐No

B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work? . . . ☐Yes ☐No

C. Do you have an eating disorder that will impact your work? Type: _____ . . . . ☐Yes ☐No

D. Do you have a learning disability that will impact your work? Type: _____ . . . . ☐Yes ☐No

E. Do you have an emotional health concern that will impact your work? . . . . . ☐Yes ☐No

F. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?

If "yes" to any question in this section, attach a statement that:

(a) Describes the concern and your management plan for addressing it while working at camp; and

(b) Describes the support needed from your work supervisor to compliment your plan. Refer to your job description if there are questions.

Paying for Health Care:

- There is usually no charge for health care provided by the camp's Health Center staff.
- Staff are financially responsible for health care provided by out-of-camp providers.
- If you will be using personal insurance while working at camp, it is your responsibility to know how to access that insurance. **Bring your insurance card and know how to use it.** Consider obtaining pre-authorization if your insurance requires this.

Emergency Contact: Whom do you want us to contact in an emergency?

First Contact: _____ Phone: (_____) _____

Relationship to You: _____

Alternate Contact: _____ Phone: (_____) _____

Relationship to You: _____

Authorization for Health Care: Parental signature required for staff less than 18 years of age.

This health history is correct insofar as I know. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp Health Center staff in providing care to me and may be reviewed by work supervisor.

Signature of Staff Person: _____ Date: _____

Signature of Parent (if needed): _____ Date: _____