Return this completed form to:

Health History Form for Camp Employee

Camp Firebird LLC
4141 Dublin Rd
Bowerston, Ohio 44695

Your Contract Start Date: ________________________ End Date: ________________
Title of Your Position: ____

International Staff: rate your ability to speak and read English:
0 Low ability 1 2 Good ability 3 4 5 Fluent in English

Name: ____
First Middle Last

Sex: ☐ Male ☐ Female Birthdate: __________________________________

Permanent Address: ____
Street Address
____
City State/Country Zip/Code

E-mail: ____

Is this your first year as a staff member? . . . . ☐ No ☐ Yes

- *Return this form to our camp office at least four weeks prior to your arrival. People hired within four weeks of their start date should not send this form; bring it with you and give it to the Health Center staff at camp.*
- *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 performing the essential functions of your position. If you have concerns regarding this, speak with the camp director prior to arrival.*
- *Information on this form is available to Health Center staff and your work supervisor(s) as necessary.*
- *Completing some portions of this form is voluntary; such areas are so marked.*

If you have questions about our camp health services, please call our office.

Allergies:

Check those that apply to you. Completion of this section is voluntary, yet helpful to healthcare staff.

_____ 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 are exposed to these medications or substances and how the reaction is managed:
____
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Nutrition:

Our expectation is that staff set an example for campers by eating the provided meal. We work with some medically prescribed diets, such as gluten-free and lactose intolerant, but cannot cater to individual food preferences. Discuss concerns with the camp director prior to the start of camp.

_____ 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)
☐ Pesco (no pork, beef, or chicken)
☐ Lacto (no meats, fish, seafood, or eggs)
☐ Ovo (no meats, fish, seafood, or dairy)
☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
☐ Vegan (no meats, seafood, eggs, or dairy)
_____ I do not eat ________________ products because of religious beliefs.

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

Completion of this section is voluntary, yet helpful to healthcare staff.

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s):

☐ Asthma
☐ Diabetes
☐ Fainting
☐ Back pain or injury

☐ Headaches, Migraines
☐ Difficulty breathing
☐ Surgical history
☐ Knee or ankle weakness

☐ Sleep problem
☐ Dysmenorrhea
☐ Seizure disorder: ________________________
☐ Other: __________________________________

Your supervisor expects that staff who have chronic health concerns are capable of performing the essential functions of the job for which they have been hired. If you have any concerns, please speak with your supervisor.

Immunization History:

Date (month/year) of your most recent tetanus immunization: ____

Have you completed the immunizations that were required for school attendance? . . . . ☐ Yes ☐ No

Medication: *All medication must be locked securely unless in the immediate possession/control of the user. All medication should be originally submitted to the Health Center.*

NOTE: Health Center staff will ask about your medication(s) to determine if the use (or non-use) of such medication will impair completion of the essential functions of your job. They may also ask about medication when you seek healthcare. Providing additional information about your medication is voluntary.

General Physical History: *If you answer "Yes" to any of these questions, provide more information at the end of this section.*

Completing this session is voluntary, but helpful to healthcare staff.

1. Have you ever been hospitalized? . . . . ☐ Yes ☐ No
2. Have you ever passed out during or after exercise? . . . . ☐ Yes ☐ No
3. Have you ever been dizzy during or after exercise? . . . . ☐ Yes ☐ No
4. Have you ever had chest pain during or after exercise? . . . . ☐ Yes ☐ No
5. Do you tire more quickly than your friends during exercise? . . . . ☐ Yes ☐ No
6. Have you ever had high blood pressure? . . . . ☐ Yes ☐ No
7. Have you ever had a racing heartbeat or skipped heartbeats? . . . . ☐ Yes ☐ No
8. Have you ever been knocked out or become unconscious? . . . . ☐ Yes ☐ No
9. Have you ever had a seizure? . . . . ☐ Yes ☐ No
10. Have you ever had a stinger, burner, or pinched nerve? . . . . ☐ Yes ☐ No
11. Have you ever had heat or muscle cramps? . . . . ☐ Yes ☐ No
12. Have you ever been dizzy or passed out in the heat? . . . . ☐ Yes ☐ No
13. 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 ☐ Leg ☐ Neck ☐ Chest
    ☐ Arm, hand ☐ Ankle ☐ Back ☐ Hip ☐ Foot

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

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

    Country: ____ Dates: ____________________________
    Country: ____ Dates: ____________________________
    Country: ____ Dates: ____________________________

Use the space below to 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 (_________)______________________

Paying for Health Care

- There is usually no charge for healthcare provided by the camp's Health Center staff.
- You are financially responsible for healthcare provided by all other providers.
- If you will be using personal insurance while working at camp, 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: *Who do you want us to contact in an emergency?*

First Contact: ____ Preferred Phone: (______)_______________ Relationship to You: ________________

Alternate Contact: ____ Preferred Phone: (______)_______________ Relationship to You: ________________

Authorization for Healthcare: *Parental signature required for staff under 18 years of age.*

This health history is correct. 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's Health Center staff in providing care to me and may be reviewed by my work supervisor(s).

Signature of Staff Person: ____ *Date:* ________________________________

Signature of Parent (if needed): ____ *Date :* ________________________________

Staff Member STOP Here.

____

Date/Time

Documentation by Health Center Staff

Initial

____________ Screening has been conducted per camp protocol and findings noted below:

A. Any signs/symptoms of illness or injury upon arrival? . . . . NO YES as noted below

B. Any history of exposure to communicable diseases? . . . . NO YES as noted below

C. Any additions, corrections, or clarifications to information on this form? . . . . NO YES as noted below

D. As necessary (see statement under "Medication"), medication has been reviewed with the healthcare provider? . . . . NO YES as noted below

E. Any signs/symptoms of head lice? . . . . NO YES as noted below

Screening Done By: ____

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EXIT NOTE: *Check one of the following:*

☐ Left camp this day with no reported illness or injury symptoms. Client's exit date: ____________________

☐ Left camp this day with the following problem/concern: ____

Summary of nursing instructions provided: ____

Exit note completed by: ______________________________________