PMBC

"Not I, But Christ."

191 Clifton Beach Road
Clifton Township, PA 18424
(570) 842-9746
www.camppmbc.com

Summer Camp Staff Health & Medical Form 2018

Staff Member's Information:

First Name:_____ Last Name:_____

Middle Initial:_____ Nickname:_____

Gender: Male Female Birthdate:_____

Emergency Contact Information for Summer Staff Member:

First Name:_____ Last Name:_____

Middle Initial:_____ Nickname:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Please Circle, is this phone:

Allow Text Messaging? Yes No Mobile Home Office

Secondary Phone:_____ Please Circle, is this phone:

Allow Text Messaging? Yes No Mobile Home Office

Email:_____

Relationship to Summer Staff: _____

Alternate Emergency Contact Information for Staff member:

First Name:_____ Last Name:_____

Middle Initial:_____ Nickname:_____

Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Please Circle, is this phone:

Allow Text Messaging? Yes No Mobile Home Office

Secondary Phone:_____ Please Circle, is this phone:

Allow Text Messaging? Yes No Mobile Home Office

Email:_____

Relationship to Summer Staff: _____

Staff Health History

Allergies: I am allergic to:

- ☐ No known allergies
- ☐ Food
- ☐ Other:_____
- ☐ Medicine
- ☐ The environment (insect; stings; etc.)

Please describe the allergy and reaction:_____

_____

Diet / Nutrition:

- ☐ I eat a regular diet
- ☐ I am lactose intolerant
- ☐ I eat a regular vegetarian diet
- ☐ I am gluten intolerant

Please describe:_____

_____

Restrictions:

- ☐ I have reviewed the program and activities of the camp and feel I can participate without restrictions.
- ☐ I have reviewed the program and activities of the camp and feel I can participate with the following restrictions or adaptations:

Please describe limitations:_____

_____

Insurance
Please provide a photocopy of the front & back of your health insurance card:

I am covered by family medical/hospital insurance: Yes No

Insurance Company:_____

Policy #:_____

Insurance Company Phone Number:_____

Immunizations

Diphtheria, tetanus, pertussis* (DTaP) or (TdaP) – Doses in Month/Year:_____

Tetanus booster* (dT) or (TdaP) – Most Recent Dose Month/Year:_____

If you have not been fully immunized, please sign the following statement: ***I understand and accept the risks from not being fully immunized.***

_____ _____

Signature (or Signature of Parent/Guardian if under 18 years old) Date

General Health History (circle yes or no; explain yes answers below)

Ever been hospitalized	Yes	No	Had fainting or dizziness	Yes	No
Ever had surgery	Yes	No	Passed out/chest pain in exercise	Yes	No
Have recurrent/chronic illnesses	Yes	No	Had monocleosis (mono) in last 12 months	Yes	No
Had a recent infectious disease	Yes	No	If female, have problems w/periods/menstruation	Yes	No
Had a recent injury	Yes	No	Have problems w/falling asleep/sleepwalking	Yes	No
Asthma/wheezing/shortness of breath	Yes	No	Ever had back/joint problems	Yes	No
Have diabetes	Yes	No	Have history of bedwetting	Yes	No
Had seizures	Yes	No	Problems with diarrhea/constipation	Yes	No
Had headaches	Yes	No	Skin problems	Yes	No
Wear glasses, contacts, protective eyewear	Yes	No			

Mental, Emotional & Social Health (circle yes or no; explain yes answers below)

Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)	Yes	No
Ever been treated for emotional or behavioral difficulties or an eating disorder	Yes	No
During the past 12 months, seen a professional to address mental/emotional health concerns	Yes	No
Had a significant life event that continues to affect the staff member's life (History of abuse, death of a loved-one, family change, adoption, foster care, new sibling, survived a disaster, etc)	Yes	No

Over the Counter Meds

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury. **Check the medication(s) you should <u>NOT</u> be given:**

- ☐ Acetaminophen (Tylenol)
- ☐ Phenylephrine decongestant (Sudafed PE)
- ☐ Antihistamine/allergy medicine
- ☐ Diphenhydramine antihistamine/allergy medicine (Benadryl)
- ☐ Sore throat spray
- ☐ Lice shampoo or cream (Nix or Elimite)
- ☐ Calamine lotion
- ☐ Laxatives for constipation (Ex-Lax)
- ☐ Ibuprofen (Advil; Motrin)
- ☐ Pseudoephedrine decongestant (Sudafed)
- ☐ Guaifenesin cough syrup (Robitussin)
- ☐ Dextromethorphan cough syrup (Robitussin DM)
- ☐ Generic cough drops
- ☐ Antibiotic cream
- ☐ Aloe
- ☐ Bismuth subsalicylate for diarrhea (Kaopectate; Pepto-Bismol)

Medications

A medication is considered anything that a person takes to maintain their health on a daily basis (including vitamins, etc.)

☐ No, I do not have medications.
☐ Yes, I have medications. If yes, continue filling out information below. If you need more space, use a separate piece of paper.

1) Medication Name:_____

Route (oral, inhaler, etc.)_____

Schedule:

☐ Breakfast Every Day
☐ Lunch Every Day
☐ Dinner Every Day
☐ Other:_____
☐ Bedtime Every Day
☐ As Needed

Reason for Medication / Comments:_____

_____

2) Medication Name:_____

Route (oral, inhaler, etc.)_____

Schedule:

☐ Breakfast Every Day
☐ Lunch Every Day
☐ Dinner Every Day
☐ Other:_____
☐ Bedtime Every Day
☐ As Needed

Reason for Medication / Comments:_____

_____

What Have We Forgotten to Ask?

Please provide any additional information about your health that you think important or that may affect your ability to fully participate in the camp program:

_____

Permission to Treat Authorization

I hereby give permission to the medical personnel to provide routine health care; to administer prescribed medications; and to administer emergency treatment for me/my child, including, but not limited to X-rays, routine tests and treatment and/or hospitalization; and to provide or arrange necessary related transportation for me/my child. I also agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

If the person named herein is a minor, it is my intention that representatives of the camp be considered "personal representatives" for the purpose of disclosing health information that is protected under the Health Insurance Portability and Accountability Act of 1996. I also agree to the disclosure to camp representatives of protected health information of the person named herein in order to provide information related to the person's ability to participate in camp activities; and if the person named herein is a minor, to provide information to the camp representatives to keep me informed of my child's health situation.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the named person. This completed form may be photocopied for trips out of camp.

By signing below, I understand and agree to abide by any restrictions placed on my activity at camp

_____ _____

Signature (or Signature of Parent/Guardian if under 18 years old) Date

Photo Waiver

I grant Pocono Mountain Bible Conference, its representatives and employees the right to use my in a photograph, video or other digital media ("photo") in any and all of its publications, including web-based publications, without payment or consideration. I understand and agree that all photos will become the property of Pocono Mountain Bible Conference and will not be returned. I hereby irrevocably authorize Pocono Mountain Bible Conference to edit, alter, copy, exhibit, publish, or distribute these photos for any lawful purpose. In addition, I waive any right to inspect or approve the finished product. Additionally, I waive any right to royalties or other compensation arising or related to the use of the photo. I hereby hold harmless, release, and forever discharge Pocono Mountain Bible Conference from all claims, demands, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization.

By signing below, I grant PMBC the right to my likeness while at camp

Signature (or Signature of of Parent/Guardian if under 18 years old) _____ Date _____

TShirt Size

- ☐ Youth Small
- ☐ Youth Medium
- ☐ Youth Large
- ☐ Adult Small
- ☐ Adult Medium
- ☐ Adult Large
- ☐ Adult XL
- ☐ Adult 2XL
- ☐ Adult 3XL

INSTRUCTIONS ONCE COMPLETE:

Please mail or email this form to Kyle Martin

kyle@camppmbc.com

PMBC
191 Clifton Beach Road
Clifton Twp. PA 18424
ATTN: Kyle Martin