Staff Health History FORM 1

Developed and Reviewed by 4-H Camp Wyomoco and the Wyoming County Health Department

Revised January 2013

Form 1 Must be Completed in Order to Attend Camp

Date will attend camp: from _____ to _____
Month/Date/Year Month/Date/Year

Name: _____
First Middle Last

___Male ___Female Birth Date: _____ Age at Arrival at Camp: ___
Month/Day/Year

Please follow the instructions below. Attach additional information if needed.

1) Complete pages 1, 2, 3 and 4 of this form and make a copy for your records.
2) Complete the top of FORM 2 (Staff Member Health Care Recommendations) and provide with FORM 1 to the Staff Member's health-care provider for review and completion.
3) After it has been completed and signed by your health-care provider, mail FORM 1 and FORM 2 to Camp Office three weeks prior to your first session on their confirmed date of attendance.

Home Address: _____
Street Address City State Zip Code

Emergency Contact #1 to be Contacted in Case of Illness or Injury:

Relationship
Name: _____ to Staff: _____ Preferred Phones: (_____)_____ (_____)_____

Email Address: _____

Home Address: _____
(If Different from Above) Street Address City State Zip Code

Emergency Contact #2 or Other Emergency Contact:

Relationship
Name: _____ to Staff: _____ Preferred Phones: (_____)_____ (_____)_____

Email Address: _____

Home Address: _____
(If Different from Above) Street Address City State Zip Code

Emergency Contact #3 if Primary Contact(s) cannot be reached:

Relationship
Name: _____ to Staff: _____ Preferred Phones: (_____)_____ (_____)_____

Allergies: ☐ No Known Allergies This Staff Member is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other

Please describe below what the Staff Member is allergic to and the reaction seen (attach a separate sheet if necessary):

Diet, Nutrition: Staff Member eats a regular diet. ☐ Staff Member eats a regular vegetarian diet. ☐ Staff Member has special food needs*.

***Please describe below any special food needs:**

Restrictions: ☐ I have reviewed the program and activities of the camp and feel the Staff Member can participate without restrictions.

☐ I have reviewed the program and activities of the camp and feel the Staff Member can participate with the following restrictions or adaptations: ***(Please describe below.)***

Medical Insurance Information:

This Staff Member is covered by family medical / hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company _____ Policy Number _____

Subscriber _____ Insurance Company Number (_____) _____

Parent/Guardian/Staff Authorization for Health Care:

This health history is correct and accurately reflects the health status of the Staff Member to whom it pertains. The person described has permission to participate in all camp activities except as noted by me and/or an examining physician. I give permission to the physician selected by the camp to order x-rays, routine tests and treatment related to the health of my staff member for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this staff member. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my staff member health record from providers who treat my staff membr and these providers may talk with the program's staff about my staff member's health status.

Signature of Parent / Guardian/Staff: _____Date:_____Relationship to Staff: _____

If for religious or other reasons you cannot sign this, contact the camp for a legal waiver which must be signed for attendance.

Staff Health History FORM 1 (con't.)

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Name: _____
First Middle Last

Date of Birth (mm/dd/year): _____

Immunization History: Provide the month and year for each immunization. Copies of immunization forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 1 Month/Year	Dose 1 Month/Year	Dose 1 Month/Year	Dose 1 Month/Year	Most Recent Dose Month/Year
Diphtheria, Tetanus, Pertussis* (DTaP) or (TdaP)						
Tetanus Booster* (dT) or (TdaP)						
Mumps, Measles, Rubella* (MMR)						
Polio * (IPV)						
Haemophilus Influenzae Type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (Chicken Pox) ☐ Had Chicken Pox Date:						
Meningococcal Meningitis (MCV4)						
Tuberculosis (TB) Test	Date:			☐ Negative	☐ Positive	

If Staff Member has not been fully immunized, please sign the following statement:

I understand and accept the risks to my staff member from not being fully immunized.

Signature of Parent / Guardian/Staff: _____ Date: _____ Relationship to Staff Member: _____

General Health History: ***Check "YES" or "NO" for each statement. Explain "YES" answers below.***

Has/Does the Staff Member:

1. Ever been hospitalized?..... Yes ☐ No
2. Ever had surgery?..... ☐ Yes ☐ No
3. Have recurrent/chronic illnesses? ..... ☐ Yes ☐ No
4. Had a recent infectious disease? ..... ☐ Yes ☐ No
5. Had a recent injury?..... ☐ Yes ☐ No
6. Had asthma / wheezing / shortness of breath?..... ☐ Yes ☐ No
7. Have diabetes? ..... ☐ Yes ☐ No
8. Had headaches?..... ☐ Yes ☐ No
9. Had seizures? ..... ☐ Yes ☐ No
10. Wear glasses, contacts or protective eyewear?..... ☐ Yes ☐ No
11. Had fainting or dizziness? ..... ☐ Yes ☐ No
12. Passed out/ had chest pain during exercise? ..... ☐ Yes ☐ No
13. Had mononucleosis ("mono") during the past 12 months?..... ☐ Yes ☐ No
14. If female, have problems with periods/menstruation?..... ☐ Yes ☐ No
15. Have problems with falling asleep/sleepwalking?..... ☐ Yes ☐ No
16. Ever had back/joint problems?..... ☐ Yes ☐ No
17. Have a history of bedwetting? ..... ☐ Yes ☐ No
18. Have problems with diarrhea/constipation?..... ☐ Yes ☐ No
19. Have any skin problems?..... ☐ Yes ☐ No
20. Traveled outside the country in the past 9 months?..... ☐ Yes ☐ No
21. Do you require medication that would impair your ability to perform your job? Yes ☐ No

Please explain "Yes" answers in the space below, noting the number of the question(s). Attach separate sheet if necessary. For travel outside the country, please name countries visited and dates of travel.

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

Has the Staff Member:

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

Please explain "Yes" answers in the space below, noting the number of the questions. The camp may contact you for additional information.

Health-Care Providers:

Name of Staff Member's primary doctor(s): _____ Phone: (_____) _____

Name of dentist(s): _____ Phone: (_____) _____

Name of orthodontist(s): _____ Phone: (_____) _____

What Have We Forgotten to Ask?: ***Please provide in the space below*** any additional information about the Staff Member's health that you think important or that may affect the Staff Member's ability to fully participate in the camp program. ***Attach additional information if needed.***

Parents/Guardians/Staff: STOP here. FORM 2 to be completed by registered Health-Care Provider. Keep a copy for your records.

Staff Health Care Recommendations FORM 2

Form must be completed and signed by a licensed health-care provider in order for any medications (prescription or over the counter) to be administered by Camp Nurse.

Name: _____
First Middle Last

Date of Birth (mm/dd/year): _____

Medical Personnel:
Please review the STAFF HEALTH HISTORY FORM (FORM 1) and complete all remaining sections of this form (FORM 2). Attach additional information if needed.

Physical exam done today: ☐ Yes ☐ No

(If "No", date of last physical: MM/DD/YEAR: _____)

Weight: _____lbs. Height: _____ft _____in
Blood Pressure: _____/_____

Diet/Nutrition:
☐ Eats a regular Diet
☐ Has a medically prescribed meal plan or dietary restrictions (describe below):

Allergies: ___ No Know Allergies
☐ To Foods (list):
☐ To Medications (list):
☐ To the Environment (insect stings, hay fever, etc.-list):
☐ Other Allergies (list):
Describe previous reactions:

The Staff Member is undergoing treatment at this time for the following conditions: (describe below) ☐ None

Other treatments/therapies to be continued at camp: (describe below) ☐ None

Do you feel that the Staff Member will require limitations or restrictions to activity while at camp: (describe below) ☐ None

Standard Over the Counter / PRN Medications

(The following medications are available in the infirmary and will be administered at the discretion of the medical staff, **only** if the Staff Member's health-care provider indicates approval.)

Medication	Administer Order		Route	Dose / Time
Acetaminophen (ex.-Tylenol)	**Yes**	**No**	PO	
Ibuprofen (ex.-Advil, Motrin)	**Yes**	**No**	PO	
Phenylephrine (ex.-Sudafed PE)	**Yes**	**No**	PO	
Antacids (ex.-Tums, Rolaids)	**Yes**	**No**	PO	
Bismuth subsalicylate (ex.-Pepto-Bismol)	**Yes**	**No**	PO	
Kaopectate	**Yes**	**No**	PO	
Diphenhydramine (ex.-Benadryl)	**Yes**	**No**	PO	
Generic Cough Drops	**Yes**	**No**	PO	
Dextromethorphan (ex.-Cough Syrup)	**Yes**	**No**	PO	
Hydrocortisone 1% cream	**Yes**	**No**	PO	
Topical antibiotic cream	**Yes**	**No**	PO	
Midol	**Yes**	**No**	PO	

Prescription Medications (Please complete with Staff Member's current regimen of scheduled medications, including inhalers. Attach additional page if needed.) All medications sent to camp must be in their original containers including inhalers which must come in their prescription labeled box. No pill boxes or unlabeled containers will be accepted.

NOTE: Prescription meds will only be administered as per the prescription label instructions.

Medication	Route	Dose	Time(s)	Diagnosis

All medications sent to camp MUST be in their ORIGINAL CONTAINERS. Medication in pill boxes or other containers WILL NOT be accepted.

For Inhalers and Epi-Pens:

Has staff member been trained in the proper use of the inhaler or epi-pen? ___Yes ☐ ___No

Parental consent for Staff Member to keep inhaler or epi-pen? ___Yes ☐ ___No Signature of Parent/Guardian/Staff: _____

Camp Wyomoco is NOT responsible for inhalers or epi-pens lost while in the Staff Member's possession.

"I have reviewed the STAFF HEALTH HISTORY FORM (FORM 1), and have discussed the camp program with the Staff Member's parent(s)/guardian(s). It is my opinion that the is physically and emotionally fit to participate in an active camp program (except as noted above).

Name of licensed provider (please print): _____ **License No.:** _____

Signature: _____ **Title:** _____ **Telephone:** _____ **Date:** _____

Office Address: _____

ACKNOWLEDGMENT OF RISK FORM-YOUTH CAMP

I hereby apply for myself to participate in the program indicated below to be conducted by the designated 4-H Camp Wyomoco and acknowledge as follows:

I fully understand and acknowledge that there are inherent risks and dangers in my participation in the camp and its programs and activities and my participation in the camp and all its activities and programs and my Staff Member's use of any equipment related to such activities and programs may result in injury, illness or death and damage to personal property. I understand other participants, accidents, forces of nature or other causes may cause these risk and dangers and I hereby fully accept these risk and dangers.

I am in good health and am above the minimum age of **eight (8)** required to participate in the camp and is able to participate in any strenuous physical activity associate therewith. I affirm that I have read all the camp materials describing the various activities and programs conducted by the camp.

NAME & LOCATION OF CAMP: 4-H Camp Wyomoco – 2780 Buffalo Road – Varysburg, NY 14167

ACTIVITIES: ALL CAMP ACTIVITIES INCLUDING BUT NOT LIMITED TO: FISHING, SAILING, CANOEING, FENCING, KAYAKING, SWIMMING, HIKING, BASEBALL, BASKETBALL, VOLLEYBALL, SOCCER, HORSE AND ARCHERY.

4-H EQUINE ACTIVITY:

- ❑ Participating in an equine activity
- ❑ Working with equines beyond club level including clinics, camps, shows
- ❑ Working with equines in mounted "over fences" activities. I (the parent or legal guardian) am aware that my Staff Member will be participating in 4-H Horse Program mounted "over fences" activities at Cornell University Cooperative Extension county, multiple county, regional, or state sponsored events. I give my Staff Member permission to participate. Mounted "over fences" classes in the NYS 4-H Horse Program could include ground rail, cross rail, and/or other over fences classes and obstacles (this does include trail class). The obstacles will be no higher than 3 foot in any of the 4-H activities.
- ❑ All of the above

I HAVE READ THE ABOVE AND BY SIGNING IT I AGREE IT IS MY INTENTION TO HAVE MYSELF PARTICIPATE IN THE CAMP AND ALL ACTIVITIES AND PROGRAMS AND I UNDERSTAND AND ACCEPT THE RISKS INVOLVED.

This shall be binding on my heirs, successors, assigns, administrators and executors. Any claims or disputes arising out of my participation in the activity shall be venued in the Supreme Court of the State of New York of the County where the County Extension office is located.

I am at least eighteen (18) years of age and I am the legal parent/guardian authorized to sign on behalf of myself and any other parent/guardian of the staff member named herein.

PARENT/ LEGAL GUARDIAN'S NAME: _____ (if under 18)

STAFF MEMBER'S NAME:_____

SIGNATURE: _____ DATE: _____

PHOTO, VIDEO, and AUDIO CONSENT AND RELEASE FORM

From time to time, photographs, videos, direct quotes, and/or audio clips may be taken of youth and adults attending Cornell Cooperative Extension events or participating in Cornell Cooperative Extension-sponsored programs and activities. Cornell Cooperative Extension requests the right to use all such photos, videos, print material and/or audio clips taken of youth and adults involved in these programs and activities. They may be used for a variety of purposes, including, but not limited to, publications, promotional brochures, promotions or showcase of programs on our Web sites, showcase of activities in local and/or national newspapers or programming, and other similar lawful purposes.

By signing this form, I consent and give permission to allow Cornell Cooperative Extension the unlimited right to use photos, videos, direct quotes, and/or audio clips that they have of me participating in Cornell Cooperative Extension programs or events. I agree to give up my rights with regards to Cornell Cooperative Extension photos, videos, direct quotes, and/or audio clips of me. Further, by signing this consent and release form, I acknowledge that I understand and agree to the above request and conditions. I sign this form freely and without inducement.

PARENT/ LEGAL GUARDIAN'S NAME: _____ (if under 18)

STAFF MEMBER'S NAME:_____

SIGNATURE: _____ DATE: _____