



BADGER DAY CAMP

# Staff Medical Form

PLEASE PRINT. FILL OUT AS COMPLETELY AS POSSIBLE.

**DISCLAIMER**

DISCLAIMER: THE INFORMATION THAT YOU PROVIDE ON THIS FORM IS NOT IN ANY WAY AFFILIATED WITH THE ACCEPTANCE PROCESS IF THE STAFF MEMBERS. THIS INFORMATION IS EXCLUSIVELY PROVIDED TO AID IN THE INDIVIDUAL CARE OF EACH STAFF MEMBER. PARENTS/GUARDIANS MUST FILL OUT THIS FORM IF THE STAFF MEMBER IS UNDER THE AGE OF 18.

NAME \_\_\_\_\_ AGE \_\_\_\_\_  
Last First Middle

HOME ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
Street Address City

## FIRST PARENT/GUARDIAN

NAME \_\_\_\_\_  
Last First Middle

HOME ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
*(if different)* Street Address City

BUSINESS ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
Street Address City

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ ADDITIONAL PHONE \_\_\_\_\_

## SECOND PARENT/GUARDIAN

NAME \_\_\_\_\_  
Last First Middle

HOME ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
*(if different)* Street Address City

BUSINESS ADDRESS \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_  
Street Address City

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ ADDITIONAL PHONE \_\_\_\_\_



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## EMERGENCY CONTACTS

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
Last First

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ ADDITIONAL PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
Last First

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ ADDITIONAL PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_  
Last First

CELL PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

WORK PHONE \_\_\_\_\_ ADDITIONAL PHONE \_\_\_\_\_

## INSURANCE INFORMATION

Indicate if staff member is covered by family medical/hospital insurance **YES** **NO**

If yes, please indicate carrier or plan name: \_\_\_\_\_

Group # \_\_\_\_\_ Phone: \_\_\_\_\_



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## ALLERGIES

FOOD ALLERGIES

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REACTION

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MEDICAL ALLERGIES

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REACTION

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OTHER ALLERGIES

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REACTION

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If it is necessary please provide any additional information about the staff members behavior, and their physical, emotional and mental health. **Rest assured that all information provided will be kept confidential.**

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## MEDICATIONS

- ✓ All medications must be accompanied by a doctor's order.
- ✓ All medications are stored/administered by camp nurse.
- ✓ Keep medications in original packaging that identifies the prescribing physician, the name of the medication, dosage and frequency of administration.

Do you take any medication that might impair your ability to perform the essential functions of your position?      **YES**      **NO**

*If yes, please be prepared to discuss the details with the camp nurse. Disclosure of such information will be treated with the strictest of confidence and be shared on a specific need-to-know basis.*

## RESTRICTIONS

Please indicate if the staff member has any dietary restrictions or restrictions to activities:

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## GENERAL QUESTIONS

Have a chronic or recurring illness/condition?	<b>YES</b>	<b>NO</b>
Ever been hospitalized?	<b>YES</b>	<b>NO</b>
Ever passed out during or after exercise?	<b>YES</b>	<b>NO</b>
Ever been dizzy during or after exercise?	<b>YES</b>	<b>NO</b>
Ever had seizures?	<b>YES</b>	<b>NO</b>
Ever had chest pain during or after exercise?	<b>YES</b>	<b>NO</b>
Ever had high blood pressure?	<b>YES</b>	<b>NO</b>
Been diagnosed with a heart murmur?	<b>YES</b>	<b>NO</b>
Have diabetes?	<b>YES</b>	<b>NO</b>
Have asthma?	<b>YES</b>	<b>NO</b>
Ever been knocked unconscious?	<b>YES</b>	<b>NO</b>

Please explain if you answered "yes" for any of the questions listed to the left.

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Date of last medical examination: \_\_\_\_\_



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## MEDICAL

NEW YORK STATE PUBLIC HEALTH LAWS REQUIRE STAFF MEMBERS TO HAVE HAD THE FOLLOWING IMMUNIZATIONS:

1. Diptheria – 3 or more doses of diptheria toxoid
2. Polio – 3 or more doses of trivalent oral poliovirus vaccine (TOPV)  
German measles or 4 or more doses of inactivated poliomyelitis vaccine (IPV)
3. Measles – 1 dose of live measles vaccine administered after age of 12 months
4. Mumps – 1 dose of live mumps vaccine administered after age of 12 months
5. German Measles – 1 dose of live rubella virus vaccine administered after age 12 months  
or setiological evidence (blood test) of rubella antibodies

Which of the following immunizations has the staff member had?

- MEASLES     
  GERMAN MEASLES     
  HEPATITIS A     
  HEPATITIS C  
 CHICKEN POX     
  MUMPS     
  HEPATITIS B

TB MANTOUX test:

TETANUS

Date of last test: \_\_\_\_\_

Date of last immunization \_\_\_\_\_

RESULT  POSITIVE  NEGATIVE

I HEREBY CERTIFY THAT I HAVE RECEIVED THE INNOCULATIONS LISTED ABOVE

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME OF FAMILY PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ TEL \_\_\_\_\_

NAME OF FAMILY DENTIST/ORTHODONTIST \_\_\_\_\_

ADDRESS \_\_\_\_\_ TEL \_\_\_\_\_



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## PARENT / GUARDIAN / ADULT STAFF AUTHORIZATION

As far as I know, the health history is complete and correct. The person herein described has permission to engage in all camp activities except as noted.

I hereby give permission to the camp to provide routine health care, administer over the counter/prescribed medications with doctors orders only, and seek emergency medical treatment including ordering x-rays or routine tests.

I agree the release of any records necessary for treatment, referral, billing or insurance purposes. I give permission to the camp to arrange necessary related transportation for me/my child.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization for the person named above with the understanding that the family will be notified as soon as possible

I also understand and agree to abide by any restrictions placed on my child's/my own participation in camp activities.

This completed form may be photocopied for trips out of camp.

SIGNATURE \_\_\_\_\_

PRINTED NAME \_\_\_\_\_ DATE \_\_\_\_\_