For Office Use

CAMP KAMAJI FOR GIRLS

2009 Staff Medical Release and Health Information Form

May 15th - August 31st Mailing Address
CAMP KAMAJI FOR GIRLS
32054 Wolf Lake Road
Cass Lake, MN 56633

Phone: 218-335-6612
Fax: 218-987-2122

August 31st - May 15th Mailing Address
CAMP KAMAJI FOR GIRLS
7436 Byron Place
St. Louis, MO 63105

Phone: 800-7KAMAJI (800-752-6254)
314-721-0475
Fax: 314-721-5309

This STAFF MEDICAL RELEASE AND HEALTH INFORMATION FORM is to completed in its entirety and authorized/signed where indicated on Page 4 of this form by the staff member or custodial parent or legal guardian (of staff member under age 18)and returned to Camp Kamaji by June 1, 2007. Please know that we, by law, cannot treat or seek medical treatment for any staff member, dispense any medications or see to any type of medical need without this form. Nor can we employ anyone who does not complete this form in its entirety and sign and date. Thank you for your cooperation.

☐ Date of Exam Within Last Year_____ ☐ Date of Last Tetanus ≤10 year_____ ☐ Copy of Form Returned to Parent for Add'l Info

☐ Form Reviewed ☐ Copy of Insurance Card Attached ☐ Parent Signed Authorization

The health and well-being of each person at Kamaji is our most important responsibility during the camp season. Achieving this depends largely on starting out with a sound base of facts about the health of each person at Kamaji ~ to that end, we must obtain accurate and current information on the general well-being of every one at camp. Kamaji's "Club Med" (a.k.a. the Infirmary, the Health Center) with its on-site physicians and nursing staff is a critical link in developing and maintaining a safe environment for Kamaji's campers and staff members. We would ask that you be as forthcoming with as much information as possible so that we can be appraised of all your medical ~ both physical and emotional ~ needs. We have found that omissions of information on this form, though well-intentioned, often occur because the person(s) completing the form are concerned that sharing information about a specific condition could adversely affect their job status. We assure you that everything you tell us will be held in the strictest of confidence and only will be shared with the medical personnel and their supervisor. If you have any questions about any information requested on the Medical Release and Health Information Form, don't hesitate to ask us. Thank you!

Sincerely,

Kathy and Mike Jay

Staff Name_____ **Birthdate**_____
Last First Initial **Month/Date/Year**

Social Security #_____

Home Address_____
Street (Apt #) City State Zip Code

Home Phone_____ **Cell Phone**_____ **Other**_____
Please Include Area Code

School Address_____
Street (Apt #) City State Zip Code

School Phone_____
Please Include Area Code

Custodial Parent(s)if under 18 years of age)_____
Last First

Parent Address_____
Street (Apt #) City State Zip Code

Parent Phone_____ **Work Phone**_____ **Other**_____
Please Include Area Code

NAME:_____ **Last/First**

FAMILY MEDICAL/INSURANCE INFORMATION

Are you/Is this person covered by medical/hospital insurance? ❒ Yes ❒ No

Does this medical coverage have a co-pay for prescription medications? ❒ Yes ❒ No

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK SIDES) TO THIS HEALTH FORM.

Carrier Name:_____ Group/Policy Number:_____

Name of Insured:_____ Relationship to Staff Member:_____

Social Security number of policy holder or insurance ID #:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Relationship to Staff Member_____

Home Phone_____ Cell Phone_____ Other_____
Please Include Area Code

Name:_____ Relationship to Staff Member_____

Home Phone_____ Cell Phone_____ Other_____
Please Include Area Code

Name:_____ Relationship to Staff Member_____

Home Phone_____ Cell Phone_____ Other_____
Please Include Area Code

STAFF MEMBER'S PHYSICIANS

Name of Primary Care Physician:_____

Phone#:_____ Service/Pager#:_____

Name of Neurologist:_____

Phone#:_____ Service/Pager#:_____

Name of Other Physician(s):_____
(e.g., allergist, gynecologist, etc.)

Phone#:_____ Service/Pager#:_____

Other (If Appropriate):_____
(Counselor, Therapist)

Phone#:_____ Service/Pager#:_____

Name of Dentist/Orthodontist:_____

Phone#:_____ Service/Pager#:_____

Name of Ophthalmologist/Eye Doctor:_____

Phone#:_____ Service/Pager#:_____

STAFF MEMBER'S HEALTH HISTORY

1. **CHILDHOOD DISEASES:** Please check those which apply to staff member::
   ❒ Measles ❒ Chicken Pox ❒ German Measles ❒ Mumps ❒ Asthma ❒ Hepatitis

2. **IMMUNIZATION HISTORY:**
   NOTE: A condition of employment includes a copy of your immunization record.

While we do request that your physician attach a copy of your up-to-date Immunization History to the 2009 Staff Health Care & Recommendation Form that s/he completes at the time of your physical exam, oftentimes we find that it is not sent with physician's form. Knowing that, we ask that you attach a copy of the same to this form so that we can have that vital information on hand at camp. Thanks for your cooperation in this matter.

3. **ALLERGIES:** List all known allergies [to medication, food, environment – insect stings, hayfever, mold, dust – other) and describe reaction/management of this reaction. (Attach additional pages as *needed).*

Known Allergies	**Reaction and Management**

4. **GENERAL:** Please check"Yes" or "No" to each of the following:

Has the staff member. . .	Yes	No	Does the staff member. . .	Yes	No
Ever been diagnosed with heart defect/disease?. . . .	❒	❒	Wear glasses, contacts or protective eye wear? **. . . .	❒	❒
Ever had seizures/convulsions?.	❒	❒	Have an orthodontic appliance being brought to camp?. . .	❒	❒
Had a recent injury/illness/infectious disease?.	❒	❒	Have an eating disorder?.	❒	❒
Ever have bleeding/clotting disorders?	❒	❒	Have frequent headaches?.	❒	❒
Had mononucleosis in past 12 months?.	❒	❒	Have problems with sleepwalking?.	❒	❒
Ever had chronic/recurring illness/condition?.	❒	❒	Have diabetes?.	❒	❒
Ever been treated for/diagnosed as ADD/ADHD?. . . .	❒	❒	Have asthma?.	❒	❒
Ever been treated for emotional/behavioral problems?	❒	❒	Have a heart murmur?.	❒	❒
Ever been hospitalized?.	❒	❒	Have back problems?.	❒	❒
Ever had surgery?	❒	❒	Have joint problems (e.g., knees, ankles)?.	❒	❒
Ever had a head injury?.	❒	❒	Have any skin problems (e.g., itching, rash, acne)?.	❒	❒
Ever been knocked unconscious?.	❒	❒	Have frequent ear infections/swimmer's ear?.	❒	❒
Ever passed out during or after exercise?.	❒	❒	Have a history of bed-wetting?.	❒	❒
Ever been dizzy during or after exercise?.	❒	❒	Have problems with diarrhea/constipation?.	❒	❒
Ever seen a professional to address mental/emotional health concerns?.	❒	❒	Had a significant life event that continues to affect the camper's life? (i.e., abuse, death of a loved one, family change, survived a disaster, other).	❒	❒
Been out of the country in the last year?.	❒	❒			

Please explain "Yes" answers in the space below noting the number of the questions. (Attach additional pages as needed). The camp may contact you for additional information.

****** **Please include (or attach a copy of) your eyeglass and/or contact lense prescription. Thank you!!**

5. **ACTIVITY RESTRICTIONS:** Explain any restrictions ~ e.g., what can't be done, what adaptations/limitations are necessary. (Attach additional pages as needed).

6. **NUTRITIONAL RESTRICTIONS:**

Camp Kamaji offers three food options at mealtimes. Please understand that we cannot individualize food plans for our campers and staff.. The only **exceptions** are if you have **food allergies** (please list these under #3 above) or specific diagnosed **"intolerances" to food**. Note: We cannot accommodate vegan diets.

Please check off all that apply to the staff member:

❒ Staff member is a vegetarian and as such eats **no** meat, including fish and poultry, whatsoever.

❒ Staff member does not eat red meat.

❒ Staff member has no preference and will basically eat anything.

❒ Staff member is lactose intolerant and may not have any dairy products whatsoever.

❒ Staff member is lactose intolerant but controls it with an over-the-counter lactose enzyme such as Lactaid. (Staff member must provide her/his own OTC medication in this situation.)

7. **MEDICATIONS:** In addition to listing below where indicated, please list ALL medications (including over-the-counter or nonprescription drugs). Attach additional pages as needed.

Notes about Medications: Minnesota State law prohibits us from dispensing any type of medication — be it prescription or over-the-counter — that is not in its original packaging/bottle with the staff member's name, the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. If the medication is to be taken "As Needed" be sure the prescription label reflects this.

❒ This person takes NO medications on a routine basis.

❒ This person takes medications as follows: (Please attach additional pages if more medications need to be listed.)

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #2_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Med #3_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

NOTE: If staff member uses any kind of inhaled medication for allergies &/or asthma, please list her peak flow zones:

Green Zone: >_____ Yellow Zone: Between _____ Red Zone: <_____

❒ This person is suspending the following medication(s) for the summer (including medications taken during the school year.) P.S. Please consider sending these medications to camp "just in case".

Med #1_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Reason for suspending _____

Med #2_____ Dosage_____ Specific times taken each day_____

Reason for taking_____

Reason for suspending _____

8. Are there any over-the-counter medications (e.g., Tylenol, Calamine, Benadryl, Pepto-Bismol, Ibuprofen, Cough Syrups, Cold Formulas, and the like) that we ***should not dispense*** to you. (Note: we do not dispense aspirin at camp for any reason unless specifically directed by a physician.) _____

AUTHORIZATION: This health history is correct and complete as far as I know. I/(if a minor) the person herein described has permission to engage in all prescribed camp activities except as noted (under #5 on Page 3 of this form) and the examining physician (as noted on the Medical Examination and Health Recommendation Form). Too, I hereby give permission to Camp Kamaji to provide routine health care, administer prescribed medications and to seek emergency medical treatment including, but not limited to, ordering x-rays, blood tests and/or other routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. And in the event that I cannot, for whatever reason, be called upon in an emergency, I hereby give permission to the physician selected by Camp Kamaji to hospitalize, secure proper treatment for, and to order injection, anesthesia and/or surgery for me or my child (if staff is a minor) as named on this 2009 Staff Medical Release and Health Information Form. I also give permission to Camp Kamaji to arrange necessary related emergency transportation for me or my child (if staff member is a minor). Additionally, I request that Camp Kamaji be given all copies of my or my child's (if a minor) health records by medical providers – selected by Camp Kamaji – who have treated me or my child (if a minor) in any medical or health related circumstance. Lastly, this completed form may be photocopied for trips out of camp and for medical treatment sought outside of camp.

SIGNATURE:_____

(must be signed by Custodial Parent/Legal Guardian if Staff Member is a minor)

PRINT NAME AS SIGNED:_____

RELATIONSHIP TO STAFF (if signed by Parent/Legal Guardian):_____ **DATE:**_____