Health Form for Habonim Dror
Camp Tavor Tzevet 2013

Return this completed form to:

Shelley Goldwater
2755 Wingate Ln. E.,
West Bend, WI 53090

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:
☐ Female ☐ Intersex, Transsexual, or Other_____ ☐ Male

Gender Identity (Choose All that Apply):
☐ Transgender ☐ Woman ☐ Man ☐ Other_____

Birthdate: _____ Age at Camp: _____

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.*

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: _____ Does this cause anaphylaxis? ☐ Yes ☐ No

Describe what happens if you eat this food and how the reaction is managed:

_____

_____

_____ I am allergic to this medication(s): _____ Does this cause anaphylaxis? ☐ Yes ☐ No

_____ I am allergic to these substances: _____ Does this cause anaphylaxis? ☐ Yes ☐ No

Describe what happens if you are exposed to these medications or substances and how the reaction is managed:

_____

_____

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. Discuss concerns with the camp director prior to the start of camp. Camp Tavor keeps kosher.*

_____ 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 beef)
☐ Pesco (no 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)

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.

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.

_____ 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: _____

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 (fainted) 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" or "burner" (pinched nerve)? . . . . . ☐ Yes ☐ No
11. Have you ever had heat cramps or muscle cramps? . . . . . ☐ Yes ☐ No
12. Have you ever been dizzy or passed out (fainted) 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 or primary care provider (PCP): _____

City, State _____ Office Phone (_____)_____

Name(s) of any medical specialists you are receiving regular care from (for example, orthopedist, dermatologist)

Type of specialist _____ Name of specialist_____

City, State _____ Office Phone (_____)_____

Type of specialist _____ Name of specialist_____

City, State _____ Office Phone (_____)_____

Name of your dentist/orthodontist: _____ Office Phone (_____)_____

Paying for Health Care

- There is no charge for healthcare provided by the Camp Moshava's health center (mirpa'ah) 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 staff member under 18 years): _____ *Date :* _____

Staff Member STOP Here.