CAMP LONGHORN INKS LAKE PIT STOP

#1 Camp Longhorn Rd
Burnet, TX 78611
512 793-2811 ext. 211
deidra@camplonghorn.com

Dear Counselors,

Camp Longhorn makes every effort to provide the best medical care for our counselors and campers. In order to do so, we require a medical form each year. Please note that we cannot use forms from the previous year because information changes and signatures must be current. We must have complete and accurate information on hand.

The staff medical form consists of 4 pages. The following information is required for each page:

- **Page 1** is a general information/contact info/authorization page. Please **complete and sign** this page as requested. If you are 18 years or older, you may sign the form yourself. Counselors younger than 18 will require a parent signature. Forms that are not signed or completed will be sent back.

- **Page 2** consists of the health history. **Counselors are no longer required to have a physical.** Please complete this page and sign if you are 18 years or older. If under 18 years, please have a parent or guardian complete and sign.

- **Page 3** is the HIPAA form. You may read the entire HIPAA agreement online at *www.camplonghorn.com*. If you are in agreement, please sign the bottom of the page. Same rule applies – if you are 18 years or older, you may sign –younger than 18, your parents must sign.

- **Page 4** requests a copy of your insurance information. If you are self insured, please indicate so on the page.

If you are bringing medications to camp, you will need to bring them to the Pit Stop. **NO medications (prescription OR over-the-counter)** can be kept in the cabins. You may self-medicate while at camp.

The forms are due May 15th. We cannot have you at camp without these forms. Thanks so much for your attentiveness to the forms.

ATTAWAYTOGO!
Camp Longhorn Pit Stop

2012

CAMP LONGHORN EMPLOYEE MEDICAL FORM

Return by: **May 15th, 2012**

PLEASE CIRCLE:

CAMP: *Inks Lake* *Indian Springs* **TERM:** *1st* *2nd* *3rd* *4th*

1. **This form must be completed and signed. If under 18, this form must be signed by parents.**
2. **PLEASE ENCLOSE A COPY OF YOUR MEDICAL INSURANCE AND PRESCRIPTION DRUG CARD (FRONT & BACK) & RETURN SIGNED HIPAA FORM.**
3. **You will be responsible for Non-Job related Medical Charges**

Name_____ **Birth Date** _____ **Age**_____ **Sex** _____
Last First MI

Parent or Guardian_____Phone_____
Area/Number

Home Address_____
Street & Number City State Zip

Work Phone: _____ Cell Phone: _____

Second Parent or Guardian Emergency Contact_____

Home Address_____Phone_____
Street & Number City State Zip Area/Number

Work Phone_____ Cell Phones_____

If above contacts not available, in an emergency notify_____

Home Address_____
Street & Number City State Zip

Phone_____ Cell Phone_____ Work Phone_____

Name of Dentist/Orthodontist_____Phone:_____

Name of Family Physician: _____Phone:_____

You will be covered while employed by Camp Longhorn's worker compensation insurance for job related injuries and illnesses. All other medical care will be your responsibility. **I hereby give permission to the Camp:**

1. To provide ongoing health care.
2. To select medical personnel and to order X-rays or routine test or treatment for the person listed above.
3. To provide transportation in Camp's vehicles to out of camp medical care providers or other purposes as necessary.
4. To allow any photos or videos of employee produced by Camp Longhorn to be used by Camp Longhorn in any of its publications or promotional media. You may revoke this authorization at any time in writing which is signed by employee or parent and delivered to and acknowledged in writing by Camp Longhorn.

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

Signature of employee

_____ Date_____

Signature of Parent/Guardian (if employee is under age of 18)

_____ Date_____

Name _____Date of birth _____Age _____Male_____ Female_____

EMPLOYEES PLEASE NOTE: ***It is no longer necessary to have a physical for camp***. The following health history must be completed, **signed** and sent in to our office before arriving at camp. Signature of Parent/Guardian required for employees less than 18 years of age.

HEALTH HISTORY

Are you now or have you ever been treated for the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension	
		Heart Defect/ Disease	
		Bleeding, Clotting Disorder	
		Lung/Respiratory disease	
		Ear/Sinus problems	
		Muscular/Skeletal condition	
		Psychiatric/psychological/emotional difficulties	
		Thyroid disease	
		Kidney disease	
		Seizures	
		Sleep disorders	
		Abdominal/digestive problems	
		Fainting	
		Head injury w/loss of consciousness within the past 5 years	
		Back/spinal surgery, recurring back problems	
		Serious injury: Date:	
		Surgery	
		Mononucleosis: Date:	
		Other Condition:	
		Medications at camp? List below:	**Reason for taking**:

ALLERGIES OR REACTIONS TO:

Please circle "no" or "yes" If "yes" list allergy

MEDICATION: NO YES

FOOD, PLANT, INSECTS: NO YES

IMMUNIZATIONS

If you had disease, put "D" and the year. If immunized, put year of ***last*** *booster. If not immunized, put "No"*
(State form required for Exemption to Immunizations)

Tetanus _____
Pertussis_____
Diphtheria_____
MMR _____
(Measles, Mumps, Rubella)
Chicken Pox_____
(Varicella)
Meningococcal_____
Hepatitis B

Camp Longhorn employees must be able to meet certain physical requirements. The physical demands described here are minimum requirements that must be met to successfully perform the essential functions of the job:

Employees are regularly required to stand and walk for long periods of time on uneven, varied terrain, to lift and or move up to 50 lbs. The job requires that employees have good eye hand coordination and manual dexterity to manipulate outdoor equipment and camp activities. Vision and hearing must be correctable to normal range and employees must be able to communicate effectively to campers and other staff. Employees will be exposed daily to sun, heat and other weather conditions and are required to tolerate and thrive in these elements. Employees must be willing to live in a camp setting, work irregular hours while maintaining high energy and enthusiasm to keep pace with campers age 8-16.

I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. The Health History form is correct to the best of my knowledge.

Signature of Employee _____ Date_____

Signature of Parent (if employee is under 18yrs.) _____ Date_____

PRIVACY POLICY (HIPAA)

CAMP LONGHORN INKS LAKE ***CAMP LONGHORN INDIAN SPRINGS***

*The following is in compliance with the **HIPAA** law effective April 1, 2003. The entire Privacy Policy is listed on our Camp Longhorn website **www.camplonghorn.com**. Go to the homepage and "click" on HIPAA/Privacy Policy. If you do not have access to our website, you may request a copy in writing. Please send requests to:*

Deidra Robertson
Camp Longhorn Inks Lake
#1 Longhorn Rd.
Burnet, TX 78611

Helen Frady
Camp Longhorn Indian Springs
1000 Indian Springs Rd
Burnet, TX 78611

PRIVACY POLICY

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain. We are required by law to:

Keep medical information about you private.
Give you the notice of our legal duties and privacy practices with respect to medical information about you.
Follow the terms of the notice that is currently in effect.

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the changes occurs. We may use and disclose medical information about you for treatment (such as sending medical information to a specialists as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicaid); and to support health care operations (such as comparing patient data to improve treatment methods.)

We may use or disclose medical information about you without your prior authorization for several reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, worker's compensation purposes, and emergencies. We also disclose medical information when required by law, such as in response to request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders. We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information. If you choose to authorize use or disclosure you can later revoke that authorization by notifying us in writing about your decision.

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

Employee Name_____ Date_____

Signature (Parent/Guardian or Counselor) _____

(Parent's must sign if employee is under 18 yrs. of age)

PLEASE TAPE A COPY OF YOUR INSURANCE CARD(S) HERE.

PLEASE ADD CARD HOLDER BIRTHDATE & BEST NUMBER TO CALL IN AN EMERGENCY

FRONT
MEDICAL INSURANCE CARD

BACK
MEDICAL INSURANCE CARD

FRONT
MEDICAL PRESCRIPTION CARD

FRONT
MEDICAL PRESCRIPTION CARD