Health History Form for Camp Staff

**Because we want to support you, please complete this form accurately and completely.*

Return Completed Form to

Episcopal Youth Music Camp
PO Box 8116
Minneapolis, MN 55408
Questions?
Call Katrina Gadwa, Dean of Staff
651-324-0589
eymcdean@gmail.com

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Sex: _____
Month Day Year

Permanent Address: _____

City_____ State_____Zip_____

Preferred Phone #: (_____)_____ E-mail: _____

Your Volunteer position title: _____

- *Return this form to the above address at least four weeks before you arrive. People volunteering within four weeks of the camp start date should not send this form bring it with you and give it to the Health Center staff at camp.*
- *Keep a copy of the completed form for your records; note changes that occur and inform the healthcare provider of these changes.*
- *Notify the camp director if you are exposed to a communicable disease within three weeks of beginning camp.*
- *Information on this form is available to Health Center staff.*

Allergies: *Check those that apply to you.*

_____ I have no known allergies.

_____ I have an allergy to this food: _____ This causes anaphylaxis? ☐ Yes ☐ No
Describe what happens if you eat this food and how the reaction is managed:

_____

_____

_____ I am allergic to this medication/s: _____This causes anaphylaxis? ☐ Yes ☐ No

_____ I am allergic to these substances: _____ This causes anaphylaxis? ☐ Yes ☐ No
Describe what happens if you eat this food and how the reaction is managed:

_____

_____

Nutrition: *Our expectation is that staff set an example for campers by ea ting the provided menu. W e can work effectively with some medically prescribed diets but cannot cater to individual food preferences. There are times when you might need to simply not eat a served item.*

_____ 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 pork or beef) ☐ Vegan (no meats, eggs or dairy)
☐ Pesco (no pork, beef or chicken) ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
_____ I am lactose-intolerant. *Be prepared to manage your intolerance using products such as Lactaid or food avoidance, Soy milk will be provided.*
_____ I respond with an anaphylactic reaction when I eat this food: _____

Chronic Concerns: *Check all that pertain to you and provide information about supportive health care.* ***Asthma or Diabetes?***

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s): ☐ Asthma* ☐ Headaches/Migraines ☐ Sleep problem ☐ Diabetes* ☐ Difficult breathing ☐ Dysmenorrhea ☐ Fainting ☐ Surgery history ☐ Seizure disorder: _____ ☐ Back pain or injury ☐ Knee or ankle weakness ☐ Other: _____

Provide information about supportive healthcare needed for each checked item:

_____

_____

_____

Immunization History: *Provide the month & year for immunizations. Asterisked (*) immunizations must be current.*

Immunization	**Date — Month(s) & Year(s)**	**Immunization**	**Date — Month(s) & Year(s)**
Tetanus Booster*****	Current within 10 years:	Polio*****	
Varicella***** (Chicken Pox)		MMR (Mumps, Measles, Rubella)*****	
Meningitis		Pneumococcal	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	DPT (diphtheria, tetanus, pertussis)*****	
Hepatitis B		Hepatitis A	
Influenza			

Medication: *Bring enough medication to last or bring your written prescription to order a refill. Prescription meds MUST be in pharmacy containers with appropriate labels; other remedies must be in original container.*

_____ I do not take medication on a routine basis.

_____ I take routine medication (include vitamins) as noted below.

Name of Medication	**Reason for Taking It**	**Dose Given & When**	**Date Started?**
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	

General Physical History

1. Have you ever been hospitalized? ☐Yes ☐No

   Have you ever had surgery? ☐Yes ☐No

2. Have you ever passed out during or after exercise/physical exertion? ☐Yes ☐No

   Have you ever been dizzy during or after exercise/physical exertion? ☐Yes ☐No

   Have you ever had chest pain during or after exercise/physical exertion? ☐Yes ☐No

   Do you tire more quickly than your friends during exercise/physical exertion? ☐Yes ☐No

   Have you ever had high blood pressure? ☐Yes ☐No

   Have you ever been told that you had a heart murmur? ☐Yes ☐No

   Have you ever had racing of your heart or skipped heartbeats? ☐Yes ☐No

3. Do you have skin problems (itching, rashes, acne)? ☐Yes ☐No

4. Have you ever been knocked out, fainted, or become unconscious? ☐Yes ☐No

   Have you ever had a seizure? ☐Yes ☐No

   Have you ever had a stinger, burner, or pinched nerve? ☐Yes ☐No

5. Have you ever had heat or muscle cramps? ☐Yes ☐No

   Have you ever been dizzy or passed out in the heat? ☐Yes ☐No

6. 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 ☐ Thigh ☐ Neck ☐ Chest ☐ Forearm ☐ Shin/calf
   ☐ Back ☐ Wrist ☐ Hand ☐ Ankle ☐ Elbow ☐ Knee ☐ Hip ☐ Foot

   Can you lift and carry 30 pounds (14 kilograms) at least ten times without assistance or discomfort? ☐Yes ☐No

7. Have you had chicken pox or are you immunized for chicken pox? ☐Yes ☐No

8. Have you had mononucleosis in the past nine months? ☐Yes ☐No

9. Do you have an uncorrected hearing problem? ☐Yes ☐No

   Do you have an uncorrected vision (sight) problem? ☐Yes ☐No

   Do you wear glasses or contacts or use protective eye wear? ☐Yes ☐No

10. Do you smoke and/or use other tobacco products? ☐Yes ☐No

11. Do you have any piercings? ☐Yes ☐No

    If so, where? ☐ Ears ☐ Eyebrow ☐ Nose ☐ Tongue ☐ Belly Button ☐ Nipple ☐ Other: _____

12. Do you have any problems with your teeth? ☐Yes ☐No

13. Have you been in countries other than the United States in the past nine months? ☐Yes ☐No

    If yes, list the countries and the length of time spent in them.

    Country: _____ Dates: _____

    Country: _____ Dates: _____

    Country: _____ Dates: _____

14. For women: Do you have a menstrual problem (pain, irregularity, etc.)? . . . . . .☐Yes ☐No

    Explain and/or provide more detail about the General Physical Health questions to which you responded "yes."

_____

_____

_____

_____

Name of your physician: _____ Office Phone: (_____)_____

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

Mental & Emotional Health Information

A. Have you been diagnosed with attention deficit disorder (ADD) or AD/HD. . . . . ☐Yes ☐No

B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work? . . . ☐Yes ☐No

C. Do you have an eating disorder that will impact your work? Type: _____ . . . . ☐Yes ☐No

D. Do you have a learning disability that will impact your work? Type: _____ . . . . ☐Yes ☐No

E. Do you have an emotional health concern that will impact your work? . . . . . ☐Yes ☐No

F. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?

If "yes" to any question in this section, attach a statement that:

(a) Describes the concern and your management plan for addressing it while at camp; and

(b) Describes the support needed from your camp dean to compliment your plan.

Paying for Health Care:

- There is no charge for health care provided by the camp's Health Center staff.
- Volunteer Staff are financially responsible for health care provided by out-of-camp providers.
- If you will be using personal insurance while at camp, it is your responsibility to 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: Whom do you want us to contact in an emergency?

First Contact: _____ Phone: (_____) _____

Relationship to You: _____

Alternate Contact: _____ Phone: (_____) _____

Relationship to You: _____

Authorization for Health Care:

This health history is correct insofar as I know. 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 Health Center staff in providing care to me and may be reviewed by work supervisor.

Signature of Staff Person: _____ Date: _____

Camp Nursing Notes

Date/Time: _____ Initial: _____

SCREENING has been conducted per camp protocol and significant findings noted.

A. Any signs/symptoms of illness or injury upon arrival? . . . . . ☐Yes as noted below ☐No

B. Any history of exposure to communicable disease? . . . . . ☐Yes as noted below ☐No

C. Any additions, corrections or clarifications to information on health history? . . . . . ☐Yes as noted below ☐No

D. Medication given to health care provider? . . . . . ☐Yes as noted below ☐No

E. Any signs/symptoms of head lice? . . . . . ☐Yes as noted below ☐No

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

EXIT NOTE — Check one of the following: Date: _____

☐Left camp this day with no reported illness or injury symptoms.

☐Left camp this day with the following problem/concern:_____

Nursing instructions provided about concern: _____

Health Care Provider: _____