HEALTH HISTORY & EXAM RECORD / ADULT

Please attach explanations as needed.

GENERAL INFORMATION

Name:______________________________________Age:____ Birth date: ____________

EMERGENCY CONTACT Name: ____

Address: ____

Phone: (H)____________________ (W)____________________ (C)____________________

Does staff member have family medical/hospital insurance? oYes oNo

If yes, Carrier? ____________________________ Policy or Group #? ______________

Social Security # ______________________________

MEDICAL HISTORY – Please check/complete all those that apply

Previous Diseases	*Significant Allergies*	*Chronic or Recurring Illness*	
oChicken Pox	oAnimal_____________	oAsthma/lung	oAnemic
oMeasles	oFood_______________	oHeart Defect/Disease	oDiabetes/hypoglycemia
oGerman Measles	oInsect sting_________	oSeizures/epilepsy	oGastrointerological
oMumps	oMedicine/drug_________	oBleeding Disorder	oDermatological
oOther	oPlant/pollen__________	oHypertension	oOther___________

Other Health Concerns

oDental appliance	oMotion Sickness	oFrequent headaches
oSleep walk/nightmares	odizzy spells/Fainting	oFrequent nosebleed
oConstipation	oSight impairment	oHearing impairment

oOther ____

oCurrently under medical care ____ ____

oRequire special dietary modifications ____________________________________

ooPrevious operation/hospital____

oBone/joint injury past 12 mo.____

oIllness past 12 mo.____

oPhysical or mental impairment? _______________________________________

oWear contact lenses? Y or N

IMMUNIZATION RECORD

Year of:	Basic	Last Booster
DTP	______	______
TD/tetanus	______	______
Rubella	______	______
Measles/Rubella	______	______
Mumps	______	______
Polio	______	______
Influenza B	______	______
Hepatitis B	______	______
Tuberculin test (Most recent)	______	______
Meningitis(MCV4)	______	

Other______________________________

DATES MUST BE PROVIDED – "current" is not acceptable

MEDICATIONS –*List all current medications to be taken routinely at camp including dosage and when taken.*

____

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____

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____

____

***Any medication brought must be in the original container, listed here, having staff member's name and current dosage.**

Camp Use:Temp: ________ **Head:** ___Clear ____Active **Feet:** ___Clear ___Active

HEALTH CARE & PERMISSION

Staff member must initial & sign all statements. If staff member is a minor, a parent must sign.

________ I give my permission for first aid techniques & simple health care to be administered as the need INITIALS arises. I understand in the event of any serious injury or illness to myself, the camp officials reserve the right to seek professional medical attention including but not limited to consultation with doctors, EMS, transportation, and hospitalization.

________ INITIALS I understand that the Camp Health Supervisor will have the following medications on hand and can be given as indicated:

- o acetaminophen (i.e. Tylenol)
- o ibuprofen (i.e. Advil)
- o decongestant (i.e. Sudafed)
- o antihistamine (i.e. Benadryl)
- o antihistamine cream
- o antibacterial ointment
- o antacid tablet (i.e. Tums)
- o additional medications as indicated/prescribed by doctor/nurse

________ INITIALS I understand the GSDSW policy states that all staff members must have a completed health examination on file with the camp that is no older than 12 months upon the beginning of the work session. I understand that it is my responsibility to insure that this form is at the council office 2 weeks prior to my arrival at camp.

________ INITIALS I understand all campers & staff members will be screened during check-in for signs & symptoms of illness (i.e. elevated oral tem.) and contagious disease/infestation (i.e. lice & foot fungus) and will NOT be allowed to stay at camp based on such findings until resolved.

I hereby attest that all information listed on this form is complete and accurate. To the best of my knowledge I am in acceptable health, physical ability, and emotionally ready to fully participate/work at camp. I understand that I will be allowed to participate in all activities associated with the enrolled event with the exceptions that are noted by physician or myself. This form maybe copied for trips out of camp.

Staff member's/parent's signature: ______________________________ Date__________

HEALTH EXAMINATION – To be completed by a physician.

Physical Examination:

Check = Satisfactory for camp participation **X** = Not satisfactory - modified/limited participation

_____height (___ft. ___in.) _____lungs _____posture/spine _____feet

_____weight (______lbs.) _____nose _____abdomen

_____blood pressure (____/____) _____eyes _____throat _____general physical status

_____heart _____ears _____skin _____general emotional status

Please explain any X findings from above and give recommendations &/or restrictions while at camp:

____

____

____

____

If under the care of a physician for current conditions, please indicate treatments & medications:

____

____

____

Explanation of any chronic or recurring illness, or health concerns as listed on the medical history:

____

____

____

PHYSICIAN'S STATEMENT: Based on the staff member's physical examination, in my opinion, this person has suitable physical, mental and emotional health to fully participate/work or to participate/work with the recommendations/restrictions indicated in a rustic outdoor living with standard camp activities and potential high-risk activities (i.e. horseback riding, rappelling, hiking, swimming).

Licensed Physician's signature: ______________________________

Printed Name: ______________________ Phone: ______________

Date Examination Completed: ______________ by ______________*

***Physician signature must be on the form for validity of the exam if completed by a nurse or physician's assistant.**