STAFF HEALTH HISTORY FORM *2012*

Staff Member's ______________________________
LAST NAME **FIRST NAME**

Dear Parents of minor staff members,

In order to insure the safety of your child it is imperative that you complete this health history and liability form and return it to our office immediately. ***Please sign all areas marked "X".***

Mail this form to the address below by June 1, 2012

CALI-CAMP at Big Rock Ranch
1717 Old Topanga Canyon Road
Topanga, CA 90290
(310) 455-0404 FAX (310) 455-0408

"Health History Form STAFF Participants"

Developed and approved by the American Camp Association and the American Academy of Pediatrics.

The information on this form is not a part of the staff member acceptance process, but rather, gathered information to assist us in identifying appropriate care. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp. Please provide complete information so that the camp can be aware of your needs.

Name ______________________________ Birth Date ___________Age as of 6/12_________
Last *First* *Middle*

[ ] Male [ ] Female

Home address ____
Street Address *City* *State* *Zip Code*

(if minor staff member – please complete)

Mother's Name ______________________Home Phone _______________Cell Phone _______________

Father's Name ______________________Home Phone _______________Cell Phone _______________

Mother's email address ______________________ Father's email address ______________________

Home address ____
Street Address *City* *State* *Zip Code*

Business address ____
Street Address *City* *State* *Zip Code*

If not available, and in an emergency please notify ________________Relationship______________

Home Phone ______________________________ Cell Phone ______________________________

Home address ____
Street Address *City* *State* *Zip Code*

Insurance Information: Is the participant covered by family medical insurance? [ ] Yes [ ] No

If **yes**, please indicate carrier or plan name ______________________________Group No. ____________________

Name of insured ________________________Relationship to participant ______________________________

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IMPORTANT! - These boxes must be complete for staff attendance at camp*

Authorizations: This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted. I hereby give permission to Cali-Camp to provide routine health care, administer prescribed medications and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I also give permission to the camp to arrange necessary related transportation for staff member. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Cali-Camp to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp.

Staff Member's Signature X_____________________ Printed Name _______________________ Date ________

(if staff member is a minor)
Signature of parent/guardian X_____________________ Printed Name _______________________ Date ________

I also understand and agree to abide by any restrictions placed on my participation in camp activities.

Signature of camp staff member X____ Date_______________

Signature of minor or minor's guardian X_____________________________________ Date_______________

**If for religious reasons you cannot sign this, contact the camp for a legal waiver, which must be signed for attendance.*

ALLERGIES – please list all known. Describe the reaction and management of the reaction.

Medication allergies (list)
____

Food allergies (list)
____

Other allergies (list) - include bee and insect stings, hay fever, asthma, animal dander, etc.
____

MEDICATIONS BEING TAKEN
Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Bring or send enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

[ ] This person **takes NO medications** on a routine basis or [ ] This person **takes medications** as follows:
Med No. 1____________________Dosage ______ Specific times taken each day ____ Reason for taking _________________________
Med No. 2 ____________________ Dosage ______ Specific times taken each day ____ Reason for taking _________________________

Attach additional pages for more medications. Please identify any medications taken during the school year that the person does or may not take during the summer: ____

RESTRICTIONS (The following restrictions apply to this individual)
Does not eat: [ ] Red meat [ ] Pork [ ] Dairy Products [ ] Poultry [ ] Seafood [ ] Eggs Other ___________________________

Explain any restrictions to activities (list what cannot be done and any adaptations or limitation that are necessary)
____

SPECIAL NEEDS (Discuss any special needs that your child may have) **this information will remain confidential**_______________________
____
____

GENERAL QUESTIONS **Please explain any "Yes" answers below**

		No	Yes
1.	Had any recent injury, illness or infectious disease?		
2.	Have a chronic or recurring illness/condition?		
3.	Ever been hospitalized?		
4.	Ever had surgery?		
5.	Have frequent headaches?		
6.	Ever had a head injury?		
7.	Ever been knocked unconscious?		
8.	Wear glasses, contacts or protective eye wear?		
9.	Ever have frequent ear infections?		
10.	Ever passed out during or after exercise?		
11.	Ever been dizzy during or after exercise?		
12.	Ever had a seizure?		
13.	Ever been diagnosed with a heart problem?		

		No	Yes
14.	Do you wear an orthodontic appliance?		
15.	Have any skin problems (e.g. rash, acne, itching)?		
16.	Have diabetes?		
17.	Have asthma?		
18.	Have problems with diarrhea / constipation?		
19.	Have a bed wetting problems?		
20.	Have any eating disorders?		
21.	Have emotional problems and using a therapist?		

Please explain any "yes" answers. Note the number

DATE OF LAST IMMUNIZATION: Tetanus ___/___ Diptheria ___/___ Polio ___/___ Mumps ___/___
Measles ___/___ German Measles ___/___ Tuberculin Test ___/___ Whooping Cough ___/___

PLEASE ATTACH *A COPY* OF THE IMMUNIZATION RECORD IF IT IS AVAILABLE.

DOCTORS TO CONTACT:

Name of pediatrician or family physician ____ Phone ________________________
Name of dentist or orthodontist ____ Phone ________________________
Name of therapist or counselor ____ Phone ________________________
Other doctor or professional of importance ____ Phone ________________________

Use this space to provide any additional information about the participant's behavior and physical, emotional or mental health about which the camp should be aware: (i.e., fears, phobias, shyness) **this information will remain confidential.**

____
____
____
____

IN CASE OF AN EMERGENCY PLEASE NOTIFY:

1. ____
Name and Relationship Number and Street City Zip Code

Home Phone ( )______-___________ Work Phone ( )______-___________ Cell Phone ( )______-________

2. ____
Name and Relationship Number and Street City Zip Code

Home Phone ( )______-___________ Work Phone ( )______-___________ Cell Phone ( )______-________

Insurance Carrier: __________________________________ Policy Number: _________________Expiration: ________

I HAVE READ THE ABOVE RELEASE OF LIABILITY AND ASSUMPTION OF RISK, INCLUDING THE REGISTRATION TERMS IN THE BROCHURE, AND MEDICAL EMERGENCY INFORMATION. I FULLY UNDERSTAND ITS TERMS AND UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT. I AGREE TO ALL OF THE TERMS OF THE RELEASE OF LIABILITY AND ASSUMPTION OF RISK, INCLUDING BUT NOT LIMITED TO THAT PORTION WHICH LIMITS THE RESPONSIBILITY OF CALI-CAMP SUMMER DAY CAMP. I FURTHER REPRESENT AND WARRANT THAT I HAVE SIGNED THIS DOCUMENT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Staff Member or Parent or Guardian ***Signature*** **X** _______________________________________ Date____________

Print First and Last Name ____