Staff Member Health History Form

Summer at Park
171 Goddard Avenue
Brookline, MA 02445

617-274-6024 PHONE
617-730-8932 FAX
summerprograms@parkschool.org

Name of staff member _____ Nickname _____ DOB _____ ☐ M ☐ F

Home address _____

City/State/Zip _____ Home phone _____

Parent(s)/Guardian(s) _____ Work or cell phone _____

_____

Local emergency contact _____ Phone _____

Please provide the names and phone numbers of your health care providers

Name of physician _____ Phone _____

Medical insurance carrier _____ Policy or group # _____

Medications being taken

Please list ALL medications taken routinely (including over-the-counter or nonprescription drugs). If our nurse is required to administer medication, please bring enough to last the entire time at camp. Medications should be brought to camp in the **original labeled** pharmacy container.

☐ **I take NO medications** on a routine basis. OR ☐ **I take medications** as follows:

Medication 1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Medication 2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

Restrictions

Does not eat: ☐ Red meat ☐ Pork ☐ Dairy products ☐ Poultry ☐ Seafood ☐ Eggs ☐ Other (describe):

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary).

(continued on back)

Please complete the following section in full and add dates where appropriate. A checked item must have an explanation in the note section.

Illnesses

- ☐ Frequent ear infections
- ☐ Diabetes (or insulin?)
- ☐ *Exposure to* TB?
- ☐ Frequent strep throat
- ☐ Bleeding/clotting disorder
- ☐ *Exposure to* HIV?
- ☐ Heart disease/defect
- ☐ Asthma—inhaler used? **Y** or **N**
- ☐ *Exposure to* Hepatitis B?
- ☐ Seizures (convulsions)
- ☐ Attention Deficit Disorder

Allergies

- ☐ Seasonal (hay fever)
- ☐ Nuts *(life-threatening?* ☐ *)*
- ☐ Poison ivy
- ☐ Other foods *(life-threatening?* ☐ *)*
- ☐ Medications
- ☐ Lactose intolerance
- ☐ Insect stings *(life-threatening?* ☐ *)*
- ☐ Dermatologic problems (e.g., eczema)

Diseases

- ☐ Chicken Pox
- ☐ Whooping cough
- ☐ Lyme disease
- ☐ Measles
- ☐ Fifth's disease
- ☐ German Measles
- ☐ Coxsackie virus
- ☐ Mumps
- ☐ Positive TB test; x-ray: _____

Explanations of anything checked above:

Operations/serious injuries/hospitalizations:

Chronic or recurring illness/special needs/special concerns or considerations:

Use this space to provide any additional information about physical, emotional, or mental health about which the camp should be aware.

Signature of staff member _____ **Date** _____

If staff member is under 18 years of age, parent/guardian authorization must be completed:

This health history is correct so far as I know, and the person herein described has permission to engage in all activities except as noted.

Emergency Authorization: I hereby give permission to the medical personnel selected by the camp director to order x-rays, routine tests, and treatment for this person, and, in the event I or my physician cannot be reached in an emergency, I hereby give permission to the physician selected by the program director to hospitalize, secure proper treatment for, order injection and/or anesthesia and/or surgery for the person named above. **My signature also indicates acknowledgment and permission** for over-the-counter medications that may be given to the person, such as, but not limited to Tylenol (acetaminophen), Advil (ibuprofen), Benadryl, Tums, Robitussin DM, and Non-Drowsy Dramamine (for motion sickness).

Signature of parent/guardian _____ **Date** _____