

CAMP STAFF HEALTH EXAM (Part 1 of 2: to be filled out by physician)

Return this completed form to:



Adirondack Camp
 PO Box 97, Putnam Station,
 NY 12861
 (518) 547-8261
 Fax: (518) 547-8973

Physician Name: _____

Address: _____

Phone: _____

Height: _____

Weight: _____

Blood Pressure: _____

To Physicians and Their Staff:

This person is an employee at Adirondack Camp. The job includes physical activity such as lifting equipment and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the employee's work supervisor use the information provided on this form to guide their interface with the employee. The employee can provide their job's description and list of essential functions to you. If you question the person's suitability for their job, please talk with them about your concerns and develop a plan to address that concern. You can also speak to one of our camp professionals by calling the camp. Thank you!

Name of Staff Member: _____ Date of Birth: _____

1. List the chronic health problems of this employee: None

Asthma Diabetes

Allergies Other: _____

2. List the prescription medication(s) this person will take while at camp; provide a medical order for administration.

None needed while at camp.

a. _____

b. _____

c. _____

3. List the allergies (food, medication, etc) of this person No known allergies

a. _____ Intolerance Anaphylaxis

b. _____ Intolerance Anaphylaxis

c. _____ Intolerance Anaphylaxis

Note: Our expectation is that the employee will have an EpiPen and know how to use it if anaphylaxis is part of the individual's health profile.

4. Describe other treatments needed by this person to do their job None needed

5. Describe any significant physical findings regarding this person and/or describe any limitations that may impact the employee's job performance.

No significant findings.

6. We may have neglected to ask about something you feel is needed to adequately address this person's health needs. If so, please add your comments below.

No additional comments needed.

Physician Signature: _____

Date: _____

By signing this form, you are telling us that, in your opinion, this person is both physically and emotionally ready to participate as an employee at our camp except as noted in your comments.

CAMP STAFF HEALTH HISTORY (Part 2: to be filled out by staff member)

Return Completed Form to:
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PO Box 97
Putnam Station, NY 12861
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Fax: (518) 547-8973

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Sex: _____
Month Day Year

Permanent Address: _____

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

Country of Residence: _____

Your Contract Start Date: _____ End Date: _____

Your Job Title: _____

International Staff: rate your ability to speak English. 0 1 2 3 4 5
None Good Excellent

- Return this form to our camp office at least four weeks before you arrive. Staff hired within four weeks of their 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.
- The camp expects that you arrive in good health and capable of doing the job for which you were hired.
- Information on this form is available to Health Center staff and your work supervisor(s).

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 eating the provided menu. We 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. (Note: we cannot accommodate vegan diets)

_____ I am lactose-intolerant. Be prepared to manage your intolerance using products such as Lactaid or food avoidance.

_____ 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.

_____ 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. International Staff: translate information to English.

- _____ 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?
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	

General Physical History

- Have you ever been hospitalized? Yes No
 Have you ever had surgery? Yes No
- 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
- Do you have skin problems (itching, rashes, acne)? Yes No
- 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
- Have you ever had heat or muscle cramps? Yes No
 Have you ever been dizzy or passed out in the heat? Yes No
- 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, or panic/anxiety 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? Yes No

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

- (a) Describes the concern and your management plan for addressing it while working at camp; and
- (b)** Describes the support needed from your work supervisor to compliment your plan.

Paying for Health Care:

- There is usually no charge for health care provided by the camp's Health Center staff.
- Staff is financially responsible for health care provided by out-of-camp providers that is not covered by Worker's Compensation.
- If you will be using personal insurance while working 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.

Medical Insurance: (Note: Provide a copy front and back of your insurance card with this form)

Name of Insured _____ Social Security # _____

Insurance Co. _____ Policy ID # _____

Insurance Co. Mailing Address _____

If insurance is not accepted, payment is expected at time of service:

Credit Card# _____ Exp. Date _____

3 Digit Security Code _____

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.

I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests and treatment for me. 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, anesthesia and/or surgery for me as named above. This form may be photocopied for use out of Camp.

Signature of Staff Person: _____ Date: _____