

CAMP KAMAJI FOR GIRLS

2010 Staff Health Information Form

May 15th - August 31st Mailing Address

CAMP KAMAJI FOR GIRLS
32054 Wolf Lake Road
Cass Lake, MN 56633
Phone: 218-335-6612

August 31st - May 15th Mailing Address

CAMP KAMAJI FOR GIRLS
7436 Byron Place
St. Louis, MO 63105
Phone: 314-721-0475

This 2010 STAFF HEALTH INFORMATION FORM is to be completed in its entirety and authorized/signed where indicated on Page 4 of this form by the staff member or custodial parent or legal guardian (of staff member under age 18) and returned to Camp Kamaji by June 1, 2010. Please know that we, by law, cannot treat or seek medical treatment for any staff member, dispense any medications or see to any type of medical need without this form. Nor can we employ anyone who does not complete this form in its entirety and sign and date. Thank you for your cooperation.

The health and well-being of each person at Kamaji is our most important responsibility during the camp season. Achieving this depends largely on starting out with a sound base of facts about the health of each person at Kamaji — to that end, we must obtain accurate and current information on the general well-being of every one at camp. Kamaji's "Club Med" (a.k.a. the Health Center) with its on-site physicians and nursing staff is a critical link in developing and maintaining a safe environment for Kamaji's campers and staff members. We would ask that you be as forthcoming with as much information as possible so that we can be appraised of all your medical — both physical and emotional — needs. We have found that omissions of information on this form, though well-intentioned, often occur because the person(s) completing the form is concerned that sharing information about a specific condition could adversely affect his/her job status. We assure you that everything you tell us will be held in the strictest of confidence and only be shared with the medical personnel and their supervisor. If you have any questions about any information requested on the Staff Health Information Form, don't hesitate to ask us.

Thank you!

Kathy and Mike Jay

Staff Name _____ Birthdate _____
Last First Initial Month/Date/Year

Social Security # _____

Home Address _____
Street (Apt #) City State Zip Code

Cell Phone _____ Home Phone _____
Please Include Area Code

Custodial Parent(s) if under 18 years of age _____
Last Name First Name

Parent Address _____
Street (Apt #) City State Zip Code

Parent Phone _____ Work Phone _____ Cell _____
Please Include Area Code

- Date of Exam Within Last Year _____
- Date of Last Tetanus \leq 10 year _____
- Copy of Form Returned to Parent for Add'l Info _____

- Form Reviewed _____
- Copy of Insurance Card Attached _____
- Parent Signed Authorization _____

NAME:

Last/First (Please Print)

Family Medical/Insurance Information

Are you covered by family medical/hospital insurance? Yes No

Does this medical coverage have a co-pay for prescription medications? Yes No

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT AND BACK SIDES) TO THIS HEALTH FORM.

Carrier Name: _____ Group/Policy Number: _____

Name of Insured: _____ Relationship to Staff Member: _____

Social Security number of policy holder or insurance ID #: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship to Staff Member _____

Home Phone _____ Cell Phone _____ Other _____
Please Include Area Code

Name: _____ Relationship to Staff Member _____

Home Phone _____ Cell Phone _____ Other _____
Please Include Area Code

Name: _____ Relationship to Staff Member _____

Home Phone _____ Cell Phone _____ Other _____
Please Include Area Code

STAFF MEMBER'S PHYSICIANS

Name of Primary Care Physician: _____

Phone#: _____ Service/Pager#: _____

Name of Other Physician(s) with speciality: _____
(e.g., neurologist, allergist, gynecologist, etc.)

Phone#: _____ Service/Pager#: _____

Name of Other Physician(s) with speciality: _____

Phone#: _____ Service/Pager#: _____

Name of Other Physician(s) with speciality: _____

Phone#: _____ Service/Pager#: _____

Other (If Appropriate): _____
(Counselor, Therapist)

Phone#: _____ Service/Pager#: _____

Name of Dentist/Orthodontist: _____

Phone#: _____ Service/Pager#: _____

Name of Ophthalmologist/Eye Doctor: _____

Phone#: _____ Service/Pager#: _____

STAFF MEMBER'S HEALTH HISTORY

1. Immunization History:

While we do request that your physician attach a copy of your up-to-date Immunization History to the 2010 Medical Examination Form that s/he completes at the time of your physical exam, oftentimes we find that it is not sent with physician's form. Knowing that, we ask that you attach a copy of the same to this form so that we can have that vital information on hand at camp. Thanks for your cooperation in this matter.

2. **Allergies:** List all known allergies [to medication, food, environment – insect stings, hayfever, mold, dust – other] and describe reaction/management of this reaction. (Attach additional pages as *needed*).

Known Allergies

Reaction and Management

_____	_____
_____	_____
_____	_____
_____	_____

3. **GENERAL:** Please check "Yes" or "No" to each of the following:

Have you . . .	Yes	No	Do you . . .	Yes	No
Ever been diagnosed with heart defect/disease? . . .	<input type="checkbox"/>	<input type="checkbox"/>	Wear glasses, contacts or protective eye wear? ** . . .	<input type="checkbox"/>	<input type="checkbox"/>
Ever had seizures/convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	Have an orthodontic appliance being brought to camp? . . .	<input type="checkbox"/>	<input type="checkbox"/>
Had a recent injury/illness/infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	Have an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
Ever have bleeding/clotting disorders?	<input type="checkbox"/>	<input type="checkbox"/>	Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
Had mononucleosis in past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had chronic/recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been treated for/diagnosed as ADD/ADHD?	<input type="checkbox"/>	<input type="checkbox"/>	Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been treated for emotional/behavioral problems?	<input type="checkbox"/>	<input type="checkbox"/>	Have a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	Have back problems?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Have joint problems (e.g., knees, ankles)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	Have any skin problems (e.g., itching, rash, acne)?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	Have frequent ear infections/swimmer's ear?	<input type="checkbox"/>	<input type="checkbox"/>
Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	Have problems with diarrhea/constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Ever seen a professional to address mental/	<input type="checkbox"/>	<input type="checkbox"/>	Had a significant life event that continues to affect the	<input type="checkbox"/>	<input type="checkbox"/>
emotional health concerns?			your life? (i.e., abuse, death of a loved one,		
Been out of the country in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	family change, survived a disaster, other)		
Either had H1N1(swine flu) or been immunized					
against it in 2009 or 2010?	<input type="checkbox"/>	<input type="checkbox"/>			

Please explain "Yes" answers in the space below noting the number of the questions. (Attach additional pages as needed). The camp may contact you for additional information.

If female, have you menstruated? Yes No If **YES**, is your menstrual history normal? Yes No

- ** **Please include (or attach a copy of) your eyeglass and/or contact lense prescription. Thank you!!**

4. **ACTIVITY RESTRICTIONS:** Explain any restrictions (e.g., what can't be done, what adaptations/limitations are necessary. Attach additional pages as needed).

5. **NUTRITIONAL RESTRICTIONS:**

Camp Kamaji offers three food options at mealtimes. Please understand that we cannot individualize food plans for our campers and staff. The only **exceptions** are if you have **food allergies** (please list these under # 2 above) or specific diagnosed "**intolerances**" to food. Note: We cannot accommodate vegan diets.

Please check off all that apply to the staff member:

- Staff member is a vegetarian and as such eats **no** meat, including fish and poultry, whatsoever.
- Staff member does not eat red meat.
- Staff member has no preference and will basically eat anything.
- Staff member is lactose intolerant and may not have any dairy products whatsoever.
- Staff member is lactose intolerant but controls it with an over-the-counter lactose enzyme such as Lactaid. (Staff member must provide her/his own OTC medication in this situation.)

6. **MEDICATIONS:** In addition to listing below where indicated, please list ALL medications (including over-the-counter or nonprescription drugs). Attach additional pages as needed.

Notes about Medications: Minnesota State law prohibits us from dispensing any type of medication — be it prescription or over-the-counter — that is not in its original packaging/bottle with the staff member's name, the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration. If the medication is to be taken "As Needed" be sure the prescription label reflects this.

I do NOT take medications on a routine basis.

I take medications as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____

NOTE: If you use any kind of inhaled medication for allergies and/or asthma, please list your peak flow zones:
Green Zone: > Yellow Zone: Between Red Zone: <

I am suspending the following medication(s) for the summer (including medications taken during the school year.)
[Suggestion(!): Please consider taking these medications to camp "just in case".]

Med #1 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Reason for suspending _____

Med #2 _____ Dosage _____ Specific times taken each day _____
Reason for taking _____
Reason for suspending _____

7. Are there **any** over-the-counter medications — Aloe, Antibiotic Cream, Antifungal Cream/Spray (Lamisil, Lotrimine, Tinactine), Antihistamines/Allergy Medicines (Benadryl, Clariton, Zyrtec), Calamine, Pepto-Bismol, Cough Drops/Syrups, Cold Formulas, Ibuprofen, Kaopectate, Lice Shampoo (Ovide, Elimite, Nix), Sudafed, Tylenol (including Meltaways) and the like) that we should not dispense to you. (Note: We do not dispense aspirin at camp for any reason unless specifically directed by a staff member's physician.) _____

AUTHORIZATION: This health history is correct and accurately reflects the health status of the staff member to which it pertains. I/(if a minor) the person herein described has permission to engage in all prescribed camp activities except as noted (under #4 on Page 3 of this form) and the examining physician (as noted on the Medical Examination Form). I understand that the information on this form will be shared on a 'need to know' basis with Camp Kamaji staff. I give permission to photocopy this form for trips out of camp and for medical treatment sought outside of camp.

For the period beginning June 1, 2010 and ending August 31, 2010 I also give permission to those physician(s) and health care providers selected by Camp Kamaji to provide routine health care, administer prescribed medications and to seek emergency medical treatment including, but not limited to, ordering x-rays, blood tests and/or other routine tests. I agree to the release of any records necessary for treatment, referral, billing or insurance purposes. And, in the event that I cannot be called upon in an emergency, I hereby give permission to those physicians/healthcare providers selected by Camp Kamaji to hospitalize, secure proper treatment for, and to order injection, anesthesia and/or surgery for me as named on this 2010 Staff Health Information Form. I also give permission to Camp Kamaji to arrange necessary related emergency transportation for me. Additionally, I request that Camp Kamaji be given all copies of my health records by medical providers who have treated me in any medical or health related circumstance and ask that attending health care providers who treat me talk directly with Camp Kamaji staff about my health status.

SIGNATURE: _____
(must be signed by Custodial Parent/Legal Guardian if Staff Member is a minor)

PRINT NAME AS SIGNED: _____

RELATIONSHIP TO STAFF (if signed by Parent/Legal Guardian): _____ **DATE:** _____