2018

Below The Rim Basketball CAMP

STAFF MEDICAL/HEALTH HISTORY FORM, 18 AND OVER

Name: _____ **Phone #** _____

Address: _____

Date of Birth: _____ Sex: _____ Age: _____

Person to Notify in Case of Emergency:

1. Name:_____ Relationship: _____

   Phone #(Home): _____ Phone #(Work): _____

2. Name:_____ Relationship: _____

   Phone #(Home): _____ Phone #(Work): _____

Name of Personal Physician: _____ Phone #: _____

Address: _____

Date of Last Physical Exam: _____

By Whom (if other than physician named above):_____

Health Insurance Carrier: _____

Policy or Group #:_____

Have you been hospitalized within the past year? _____

If yes, for what reason? _____

_____

_____

Are you currently on any medication or have a medical condition that could impair your ability to perform the essential functions of your position? If yes, please discuss this with one of the camp nurses during orientation. Remember that if any medication is brought onto the camp grounds (unless it is kept in your car, it should be kept in the nurse's office.: _____

_____

_____

If there are there any other health concerns that the camp should know please bring them to the nursess' attention.

Authorization for Emergency Medical Treatment

In the case of a medical emergency , I hereby give the medical personnel selected by the camp director permission to order X-rays, routine tests and/or treatment to safeguard my health or to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery as recommended by the attending physician.
I also give permission to photocopy this form if I accompany campers on field trips.

Signature _____

Date

Name: _____

Health History (Check and Give Approximate Dates):

Frequent Ear Infections _____
Heart Defect/Disease _____
Convulsions _____
Diabetes _____
Bleeding/Clotting Disorders _____
Hypertension _____
Mononucleosis _____
Psychiatric Treatment _____
_____
_____

Allergies (Dates Not Needed)

Hay Fever _____
Poison Ivy _____
Insect Stings _____
Penicillin _____
Other Drugs _____
Asthma _____
Food Allergies _____
Other (Specify)
_____
_____

Have you ever had:

Chicken Pox _____
Mumps _____
Whooping Cough _____
Hepatitis _____
Measles _____
German Measles _____
Rheumatic Fever _____
Tb _____

"No person known to be suffering from tuberculosis in a communicable form, or having evidence of symptoms thereof, shall be allowed to work or attend a recreational camp for children in any capacity which might bring him into contact with any camper at such camp."(Mass. Department of Public Health Regulation)

If you have a history of or a current positive Mantoux Tb test we will require physician documentation that you are free of an active Tb infection. If you were treated with antibiotics please have this information included in the documentation.

Date (month & year) of last tetanus booster: _____

Please read and sign the following upon completion:

____ I state that I have not traveled to Central or South America, Eastern Europe, the Mid or Far East within the past 12 months:

____ I have traveled to Central or South America, Eastern Europe, the Mid or Far East within the past 12 months and will furnish the camp with the results of a Mantoux Tb test taken with 3 months from the start of camp.

I voluntarily state that the information provided herewith is true and accurate to the best of my knowledge and understanding at this time.

_____ _____

Signature Date

"*CERTIFICATE OF IMMUNIZATION" for* _____

If you use this form it must be filled out and signed by your physician and must include the month and year of administration and the type/name of the vaccine. All dates of shots in a series must be given, not just the last dose. Otherwise, please provide a computer printout from your physician of this information.

Immunization Record

Include "type/name of vaccine given and the date or dates (if a series) it was given" or date of titre tests showing proof of immunity.

Mantoux or Tine TB Test: _____ Result _____

DTP (Diphtheria, Pertussis, Tetanus) _____

Tetanus/Diphtheria Booster: _____
(Must be within 10 years)

Polio _____

MMR (Measles, Mumps, Rubella) _____

Measles, 2nd Dose _____

Hepatitis B _____

Varicella or certified history of chicken pox disease _____

Other _____

_____

_____

Physician's Signature: _____

Date: _____

Physician's office stamp: