

# INGHAM-OKOBOJI STAFF HEALTH FORM

## PERSONAL INFORMATION

Full Legal Name: \_\_\_\_\_

Sex: M / F (circle one) Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Parent /Guardian Name(s): \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Emergency Contact (other than a parent): \_\_\_\_\_ Phone: \_\_\_\_\_

Church Name: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

## MEDICAL INFORMATION

Are Immunizations Current? Yes No (circle one) Date of last tetanus shot: (month/year) \_\_\_\_\_

Have you tested positive for COVID-19? Y / N If so, what were the approximate dates (month/year): \_\_\_\_\_

Have you received any COVID-19 vaccinations Y / N If so, what were the approximate dates (month/year): \_\_\_\_\_ & \_\_\_\_\_

**ALLERGIES/ASTHMA/OTHER CONCERNS:** (Please indicate if allergy is airborne, touch, or ingested exposure)

Food Allergy? \_\_\_\_\_ Severity: \_\_\_\_\_

Insect Allergy? \_\_\_\_\_ Severity: \_\_\_\_\_

Other/Medication Allergies? \_\_\_\_\_ Severity: \_\_\_\_\_

Staff Member carries an: Epipen Inhaler Reason: \_\_\_\_\_

Has you ever experienced asthma (exercise induced or otherwise): Y / N

Other Medical concerns/Activity Restrictions (Diabetes, Heart Condition, Seizures, etc.) Please Give Details:

\_\_\_\_\_

Describe any other disorders or disabilities of which the camp needs to be aware (ex: ADHD, depression, anxiety, mobility limits, etc): \_\_\_\_\_

Please note any past medical treatments, surgeries or injuries which may affect you to carry out your job during camp life or in the event of emergency care: \_\_\_\_\_

Please list all medications, including OTC and vitamins, the camper will be taking at camp. Be specific and add additional pages as needed for instructions and additional items

Medication	Dose	When is it taken?	Why is it taken?

If needed, can we administer acetaminophen/ibuprofen according to recommended guidelines? Y / N

If needed, can we administer sunscreen and bug repellent? Y / N

**CAMPER’S MEDICAL INSURANCE INFORMATION:**

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy Holders Name: \_\_\_\_\_

Primary Care Dr. & Phone #: \_\_\_\_\_

**Release & Waiver of Liability Agreement/Medical & Media Release Form**

\*\*I give my permission for my child (myself) to participate in all aspects of the program except as noted.

\*\*I understand that every effort will be made to contact me if my child needs emergency medical/surgical treatment.

\*\*But if it is important to do so, I hereby give my permission to the medical staff selected by the camp to secure proper treatment, to hospitalize, to order injection, anesthesia, x-ray or surgery for my child (myself) as named above.

\*\*I understand that my insurance has primary coverage and Ingham / Okoboji insurance is secondary.

\*\*I understand choosing to be camp may increase their (my) risk of being exposed to COVID-19 and understand there may be social distancing requirements expected of this child (myself).

\*\*I give permission for any picture taken of my child (myself) to be used for promotional purposes.

**BY SIGNING THIS DOCUMENT** I (We) acknowledge these policies and affirm that all above information is accurate and true.

Signature of Parent or Guardian (if employee is minor) \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Employee \_\_\_\_\_ Date: \_\_\_\_\_

**Camp Staff Use:**

Screened upon arrival to work:

Medications stored in secure location:

Code: \_\_\_\_\_

Date/Time: \_\_\_\_\_

Initials: \_\_\_\_\_