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Staff Medical Form

PART I. To be completed by Staff Member:

Employee Name _____ Date of Birth ___/___/___ Sex: M F
Parent or Guardian Name _____ Phone (home) () _____ Phone (work) () _____
Home Address _____
Emergency contact: _____ Relationship to Employee _____
Emergency Phone Contact: Day: () _____ Evening: () _____

Insurance Information:

Are you covered by family medical/hospital insurance? Yes No
If so, indicate carrier or plan name: _____ Group # _____
Carrier Address: _____ Name of Insured: _____
Relationship to participant: _____ **COPY OF INSURANCE CARD, BOTH SIDES, MUST ACCOMPANY THIS FORM**

Health History:

Check: Give approximate dates

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

Diseases:

_____ Chicken Pox (Varicella)
_____ Measles
_____ German Measles

Allergies (Dates not needed)

_____ Hay Fever
_____ Ivy Poisoning, etc.
_____ Insect Stings
_____ Penicillin
_____ Other Drugs
_____ Asthma
_____ Food
_____ Other _____

Have you ever required any psychiatric counseling or hospitalization? Yes (please explain) No

Please explain _____

Operations or serious injuries (dates) _____

Disability or chronic or recurring illness _____

Activities encouraged or limited by physician _____

Dietary Modifications _____

MEDICATIONS BEING TAKEN:

I do not take any medication on a routine basis I take medications as follows:

Please list all medications (including over-the-counter or non-prescription drugs taken routinely).

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 _____

Attach additional pages for more medications. Identify any medications taken during the school year that participant does/may not take during the summer.

Name of dentist/orthodontist _____ Phone () _____

Name of family physician _____ Phone () _____

Date of last physical examination ___/___/___

Employee Consent: This health history is correct as far as I know and I may participate in all camp activities except as noted.

Employee Signature _____ Date _____

Part II. TO BE COMPLETED BY PHYSICIAN:

IMMUNIZATION HISTORY

Required immunizations must be determined locally. Please record the date (month and year) of basic immunization and most recent booster doses.

Vaccines	Year of Basic Immunizations	Year of Last Booster
Diphtheria Pertussis (Whooping Cough) DPT Tetanus or		
Tetanus Diphtheria TD or		
Tetanus		
Oral Polio (Sabin) TOPV		
Injectable Polio (Salk)		
Measles		
Mumps		
Rubella (German - 3 day Measles)		
Other		
Tuberculin test given (most recent)		
Haemophilus Influenza b (HIB)		
Hepatitis B		
Varicella (Chicken Pox)		
BCG		

Health Care Recommendations by Licensed Physician

I have examined the above camp applicant within the last two years. Date Examined: _____

In my opinion the employees' condition DOES DOES NOT preclude his/her participation in an active camp program.

Height: _____ Weight: _____ Blood Pressure: _____

The applicant is under the care of a physician for the following conditions: _____

Current treatment (include current medications) _____

Explanation of any reported loss of consciousness, convulsion, or concussion: _____

Does applicant have epilepsy? YES NO Does applicant have diabetes? YES NO

Recommendations and restrictions while at camp: _____

Any treatment to be continued at camp: _____

Any medication to be administered at camp (Specific dosage): _____

Any medically prescribed meal plan or dietary restrictions: _____

Any allergies (food, drugs, plants, insects, etc). _____

Additional health information: _____

Licensed Physician's Signature: _____				
Address: _____		Phone #: () _____		
Street	City	State	Zip	
Date Form Completed: ____/____/____ By*: _____				
(*Initial if completed by nurse or Physician's assistant)				

