Staff Health Form—Camp Gilead 2019

Complete and Mail to: P.O. Box 7006, Plainville, CT 06062.

This form is confidential to Camp Nurse, Health Personnel and Directors.

Important: You may ***not*** stay overnight on the campground until we have received a ***completed*** Health Form.

Last Name: _____ First Name: _____

Applicant's Name: _____ Sex: _____ DOB: ____/____/_____ Age: ____

Address: _____ City: _____State: _____Zip_____

Email: _____

INSURANCE INFORMATION: Subscriber's Name: _____ DOB: ____/____/_____

Insurance Co.: _____ Policy # _____ Phone: ( )_____

IN CASE OF EMERGENCY NOTIFY: (At least one person named below must be a Family Member, Parent or Guardian.)

Name: _____ Relationship: _____

Cell Phone: ( )_____ Home Phone: ( )_____ Work Phone: ( )_____

Name:_____ Relationship: _____

Cell Phone: ( )_____ Home Phone: ( )_____ Work Phone: ( )_____

In case of emergency, **I HEREBY GIVE PERMISSION** to the physician selected by *Camp Gilead* to hospitalize, secure proper treatment for, or to order injections, anesthesia or surgery for applicant. I give permission for the Camp Nurse to administer the prescription medications that applicant brings to Camp and non-prescription medications during Camp for the treatment of minor health issues. But NO Aspirin will be given. (Note: All prescriptions must be in the original container and turned in to the Camp Nurse during Registration. *Camp Gilead* accepts no responsibility for untoward reactions when the medication is given in accordance with the directions on the original container and/or written instructions from the applicant's physician. I accept responsibility for payment of all expenses incurred as a result of medical treatment.

To the best of my knowledge I am physically, mentally and emotionally able to participate as Staff in the Camp program. I can engage in all prescribed camp activities (except as noted by me as described on the Health Form). I understand that part of the camp experience involves activities, group living arrangements and interactions that may be new to me, and that they come with certain risks and uncertainties beyond what I may be used to dealing with at home. I am aware of these risks and I am assuming them on my behalf. I hereby waive any claim against *Camp Gilead* and its volunteers. (Note: applicant is not waiving gross negligence or any intentional acts.)

Also, I grant permission to *Camp Gilead* to use images (digital, video, photos) taken during camp activities that may include me solely for publicity purposes of *Camp Gilead*.

SIGNATURE: **X**_____ Date: _____/_____/_____

<Please Be As THOROUGH as possible>

Record of immunizations (Dates of latest boosters, as much as possible.) You may attach a printout of immunization record and report of physical from physician's office. **(If you know your shots are up to date but don't know dates, just write "Up-to-Date.")**

DPT (Date)	Oral Polio (Sabin) (Date)	Rubella (Date)	Hepatitis B (date) (If born on/after Jan.1, 1993.)
DT (Date)	MMR (Date)	Mumps (Date)	
Tetanus (Date)	Measles (Date)		

Treatment or medication to be continued at Camp: _____

Special medication precautions or medical concerns for Camp Nurse or doctors to be aware of for this applicant in a Camp setting:

Allergies: _____ **For severe allergies/medical concerns, explain on back and check here: ⑦**

Special Diet Requirements:_____ Restrictions on Activities: _____

Continued On Reverse

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Additional Information: Complete as Applicable

Confidential Health History: (Please check if applicable)

___Diabetes
___Pain Medication
___Sleepwalking
___Eating Disorder
___Anger Problems
___Nervous/Mental Disorder
___Convulsions/Seizures
___Communicable Disease
___Recent Life Changes
(Ex., divorce, death in the family, etc.)
___Asthma
___Poor Physical Condition
(Ex., overweight, smoker, etc.)

Please explain any conditions checked above: _____

_____

_____

If you have a severe life-threatening allergy, you must call *Camp Gilead* to personally register that information. Call 860.845.5720.

Please describe allergies to food, medications, etc.:

Are there specific health concerns you have?

Please list medication information below:

Medication: _____ **Reason for Taking:** _____

Dosage/Strength: _____ **Frequency/Times of Administration:** _____

Medication: _____ **Reason for Taking:** _____

Dosage/Strength: _____ **Frequency/Times of Administration:** _____

Medication: _____ **Reason for Taking:** _____

Dosage/Strength: _____ **Frequency/Times of Administration:** _____

Box Below is For Camp Nurse Use Only

Notations and Special Instructions:

1. _____
2. _____
3. _____