USGTC Summer Camps

2018 Staff Health Form

USGTC Summer Camp
PO Box 4088, Tequesta, FL 33469
Email to USGTC@bellsouth.net

- It is a requirement of the Commonwealth of Massachusetts that all seasonal staff have completed physical exam prior to working with children.
- If under the age of 21, the form must be completed by a custodial parent/guardian.
- USGTC requires that all staff provide documentation of a physical examination by a health care provider within twenty-four months preceding the opening of camp.
- Keep a copy of the completed form; notify our health care service of changes in writing.
- Our healthcare and leadership staff have access to this information.
- Questions? Call camp at 561-743-8550

Staff and/or Parents Please Complete
Pages 1 – 3 & 5

Health Care Provider Completes
Page 4

Family Information

Staff Name_____
Last First Middle

Male ☐ Female ☐ Age as of 7/16:_____ Birth Date _____
Month Day Year

If under 21 years of age, Custodial Parent/ Guardian: (circle one)

BOTH PARENTS FATHER MOTHER OTHER_____

Staff Address:

HOME Address _____

City_____ State_____

Zip_____ Country_____

Home Tel._____ Business Tel._____

Cell Tel._____ FAX/email_____

SUMMER Address_____

City _____ State_____

Zip _____ Country_____Summer Tel_____

Parent(s) (Guardian/Spouse/Significant Other:

Name_____

HOME Address _____

City_____ State_____

Zip_____ Country_____

Home Tel._____ Business Tel._____

Cell Tel._____ FAX/email_____

SUMMER Address_____

City _____ State_____

Zip _____ Country_____Summer Tel_____

Emergency Contacts:

If we cannot reach your parent/guardian in an emergency, provide contact information for other people with whom we can consult. We assume you have spoken to these emergency contacts and they are willing to assist if the need arises.

1. Name_____ Telephone_____
2. Name_____ Telephone_____

*****Parent/Guardian(if under 21) or Staff Must Complete The Following For Attendance*****

EMERGENCY CARE AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the health status of the individual to which it pertains. I hereby give permission to the medical personnel selected by USGTC Summer Camps:

- To order X-rays, routine diagnostic tests, treatment;
- To release any records necessary for treatment, referral, billing, or insurance purposes; and
- To provide or arrange necessary related transportation for me.

In the event my parent/spouse cannot be reached in an emergency, I hereby give permission to the physician selected by USGTC Camp to secure and administer treatment, including hospitalization, for the person named above. I understand the information on this form will be shared on a "need to know" basis with the USGTC Camp staff. I give permission to photocopy this form for use out of camp. In addition, USGTC Camps has permission to obtain a copy of my health record from providers who treat me and these providers may talk with the USGTC Camps' staff about my health status.

VALIDATION OF HEALTH HISTORY AND PERMISSION TO ENGAGE IN ACTIVITIES

I do hereby confirm that the health information provided is accurate and honest. Therefore, the person herein described has permission to engage in all prescribed camp activities except as noted. ****If for religious reasons you cannot sign this, camp should be contacted for a legal waiver, which must be signed for attendance.***

Signature of I parent/guardian or Staff X_____ *Date*_____

Name:_____

Health Care Providers and Insurance

Health Insurance coverage is required for each staff. ***Please include a copy of your insurance card; copy both sides of the card****.*

Name of Primary Care Provider_____ Tel_____

Name of Dentist/Orthodontist_____ Tel_____

Health Insurance Company_____ Tel_____

Name of Policy Holder_____ Policy Number_____ Group Name/Number_____

Health History – Staff Complete

Allergies: **Check all that apply. Attach additional information on separate sheet if needed.**

☐ **I have NO KNOWN ALLERGIES.**

☐ **I am ALLERGIC to this FOOD(s):**_____

Causes *anaphylaxis? ☐ **YES** ☐ **NO**

Describe typical reaction_____

Describe treatment_____

☐ **I am ALLERGIC to this MEDICATION(s):**_____

Causes *anaphylaxis? ☐ **YES** ☐ **NO**

Describe typical reaction_____

Describe treatment_____

☐ **I am ALLERGIC to the following, e.g. environmental, animals, etc.:**_____

Causes *anaphylaxis? ☐ **YES** ☐ **NO**

Describe typical reaction_____

Describe treatment_____

Nutrition: **Check all that apply. Our kitchen prepares a menu with variety; be sure you are ready to explore various foods. We can work with some medically prescribed diets but do not cater to individual food preferences. Call if you have questions.**

☐ **This individual eats a regular diet.**

☐ **This individual is the following type of vegetarian.**

☐ Semi-vegetarian (no pork or beef)
☐ Lacto-ovo (no beef, pork, chicken, seafood or fish)
☐ Pesco (no pork, beef or chicken)
☐ Vegan (no meats, seafood, eggs or dairy)

☐ **This individual does not eat pork because of faith beliefs.**

☐ **This individual is lactose intolerant. Note: our expectation is that thestaff self-manages using products such as Lactaid.**

☐ **This individual has Celiac Disease. Note: our expectation is the staff will speak with the Food Service Manager regarding specific diet.**

Chronic or Life-Threatening Health Concerns: **Check all that apply to this.**

☐ **This individual has NO CHRONIC or LIFE-THREATENING health concerns.**

☐ **This individual has the following CHRONIC health concerns. Attach additional information if needed.**

Health Concern	Comments – Treatments & approximate dates	Health Concern	Comments – Treatments& approximate dates
☐ Asthma/Respiratory Disorder	_____	☐ Frequent Colds	_____
☐ Bedwetting	_____	☐ Frequent Ear Infections	_____
☐ Bleeding Disorder	_____	☐ Headaches	_____
☐ Cardiac Disorder	_____	☐ Hospitalizations/Surgery	_____
☐ Chronic Illness	_____	☐ Metabolic Disorder/Diabetes	_____
☐ Digestive Disorder/Diet Restriction	_____	☐ Neurological Disorder/Seizures	_____
☐ Eating Disorder/Compulsions	_____	☐ Orthopedic Disorder/Activity Restriction	_____
☐ Encopresis/Constipation	_____	☐ Throat Disorder/Speech Deficit	_____
☐ Fainting	_____	☐ Other	_____

Name:_____

*Immunizations: **Physician must verify the basic immunizations and most recent booster, with record and/or blood titer test.**

Immunizations	Date(s): Month(s) & Year(s)					
DPT (Diptheria, Pertussis, Tetanus)						
Td (Tetanus)						
TdaP (Tetanus, Pertussis)						
OPV/IPV (Polio)						
MMR (Measles, Mumps, Rubella)						
Hib (Haemophilius Influenza Type B)						
Hepatitis B						
PPD/Mantoux (Tuberculosis)						
Varicella (chicken pox)						
Meningitis						
Other						

***If you have not been immunized, please explain why and/or attach supporting documentation.**_____

General History: **Check "True" or "False" for each statement.**

1. **This individual has had chicken pox** ……If True, Indicate Month/Year_____…… ☐ **True** ☐ **False**
2. **This individual has NOT had MONONUCLEOSIS ("Mono") during the past year**…… ☐ **True** ☐ **False**
3. **This individual's HEARING is within normal ranges**…… ☐ **True** ☐ **False**
4. **This individual's EYESIGHT is within normal ranges or he/she uses corrective lenses to remedy vision**…… ☐ **True** ☐ **False**
5. **This individual typically sleeps without SLEEPWALKING, SNORING, SLEEP TALKING, or making other noises**…… ☐ **True** ☐ **False**
6. **This individual is free of illness, injury or physical challenges that would effect program participation**…… ☐ **True** ☐ **False**
7. **This individual has been in countries OUTSIDE THE UNITED STATES in the past nine (9) months**…… ☐ **True** ☐ **False**
   If "True", list the countries and the length of time spent in each.

   Country_____ Country_____
   Dates_____ Dates_____

8. **Had a recent injury? If yes, please explain**_____

Mental, Emotional and Social Health: **Check "Yes" or "No" for each statement.**

1. **This individual has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD**…… ☐ **Yes** ☐ **No**
2. **This individual has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder**…… ☐ **Yes** ☐ **No**
3. **This individual has an emotional health concern (specify**_____**)** ☐ **Yes** ☐ **No**
4. **During the past academic year, this individual has seen or is currently seeing a professional to address mental/emotional concerns**…… ☐ **Yes** ☐ **No**

   If "yes" was the answer to any of the four statements above, attach a statement from your professional (e.g. psychiatrist, physician) that addresses the following three things:
   (a) Describes the concern and the management plan (including medication) while in our program;
   (b) Describes the behaviors that will indicate to our medical staff that you need a professional referral; and,
   (c) Provides a recommendation for the individual's participation in the USGTC Camp program.

5. **This individual has had a significant life event that continues to affect their life** …… **Yes** ☐ **No** ☐

   If "yes", please provide written information about the event – death of a loved one, adoption, new sibling, survived a disaster – it's impact upon your life.

Physical Examination Completed by a Licensed Provider

I have examined (Patient's Name)_____on (Date of Exam) _____.

This patient will be employed in a summer overnight/residential or a day program of USGTC Camp. The program includes physical activity (i.e. 4 hours of gymnastics coaching, tumbling and apparatus training daily) USGTC requires that all staff provide documentation of a physical examination within the twenty-four (24) months preceding the opening of camp. In order to provide proper health supervision while at camp, we ask that the licensed provider advise us of any health concerns, allergies, diet and activity restrictions. Please be specific and attach additional information on a separate sheet if necessary.

Height_____ **Weight**_____ **Pulse**_____ **Respirations**_____ **Blood Pressure**_____

Please indicate, "YES" if patient's examination is *within normal limits* or "NO" if exam is *of concern.* If "NO" is checked, please describe condition.

SYSTEM	YES	NO	COMMENT
General Appearance			
Skin			
Eyes/Vision			
Ears/Hearing			
Nose			
Mouth/Teeth			
Cardiovascular			
Lungs			
Abdomen			
Genitourinary			
Musculoeskeletal			
Neurologic			
Development			
Other			

- **The patient is under the care of a physician for the following reason(s):**_____
  _____
- **Describe the treatment(s) to be continued at USGTC for this patient:**_____
  _____
  _____

ALLERGY HISTORY

- **This patient has allergies. If "yes", please document allergy, typical response and treatment plan below**…… ☐ **YES** ☐ **NO**

ALLERGEN	Typical Reaction	Treatment Plan

RECOMMENDATIONS WHILE AT CAMP

- **This patient <u>DOES HAVE</u> ACTIVITY RESTRICTIONS**…….. ☐ **YES** ☐ **NO**
  Describe_____
- **This patient <u>DOES HAVE</u> DIETARY RESTRICTIONS**…….. ☐ **YES** ☐ **NO**
  Describe_____
- **This patient <u>WILL RECEIVE</u> MEDICATIONS while at camp**…….. ☐ **YES** ☐ **NO**
  (Prescription and/or Over-the-Counter) ***If "YES", please complete the attached <u>Medication Authorization Form</u> (page 5). Please use one form per medication.***
- **<u>ADDITIONAL INFORMATION</u>: We would appreciate any additional information you may have that would help us to provide optimal care for this individual. Attach a separate sheet for additional information, if necessary.**

VALIDATION OF EXAMINATION

In my opinion the above individual may participate in an active camp program with noted restrictions.

Licensed Provider Signature (MD/NP)_____***Date***_____

Address_____***City***_____***State***_____***Zip***_____
Country_____***Office Telephone***_____***Fax***_____

USGTC Summer Camps

Medication Authorization Form

Return by July 15 to
USGTC Summer Camp, PO Box 4088
Tequesta, FL 33469

Licensed Provider and Staff or Parent/Guardian Responsibility for Prescription Medication, Non-Prescription Medication and/or Food Supplements

- All medications including prescription, over-the-counter medications, allergy injections, food supplements and vitamins shall have a completed Medication Authorization Form on file in order to be administered while at camp.
- All prescription and over-the-counter medications must be received in a properly labeled pharmacy prescription container bearing a current date, appropriate patient's name, drug name, and the prescribing licensed provider's name, as well as the prescribed dosage and administration time or over-the-counter packaging.
- If there are no changes in the administration of a medication as indicated on a properly labled pharmacy prescription, a parent or guardian may complete the Medication Authorization Form. With any changes to the presciption, a licensed provider must provide written documentation.
- Any over-the-counter medication can only be administered if the"Non-Prescription medication authorization form" is signed by your physician.The OTC medicatons on this form are stocked at camp.
- All medications shall be authorized by signature by a licensed provider.
- Campers with severe allergies requiring epi-pens should bring 2 pens to camp, one for their gym bag and one for the camp nurse.
- Allergy serums must come with specific instructions from prescribing allergist.

Camp Responsibility

- If the nurse or camp director questions the advisability of dispensing a medication at camp, the camp physician/nurse practitioner is to be consulted. ***All medication shall be collected and stored in their original pharmacy***
- ***Labeled container or over-the-counter packaging in the health center under the supervision of a licensed health care professional.***
- ***All medication shall be taken in the presence of and/or under the supervision of a licensed health care professional.***
- All medication records will be kept to document the dispensation of all medications at camp.
- It is the responsibility of the staff member to be responsible for their own medication schedule.
- All medications will be returned to the staff at the end of their camp session or properly disposed of if undeliverable.
- All medications and their administration will be confidential and communicated to appropriate persons on a need-to-know basis.

USGTC Summer Camps Medication Authorization Form

Name____ **Birth Date** ____________
Last First Month/Day/Year

Authorization for Dispensing of Medications for Minor

As the parent or guardian of the above named camper, I do hereby authorize the USGTC Camps health care providers to administer my child the medications as indicated below.. ****If there is a change in the prescription, the child's health care provider must provide CCSC with written documentation.***

Parent/Guardian Signature____

Completed by Licensed Provider, if prescription has changed or different than the prescription label:

Name of Licensed Provider____ **Title**______________

Telephone________________________________ **Signature**__________________________________

Medication____

Route of Administration___________________ **Dosage**__________________________________

Frequency_______________________________ **Time(s) of Administration**___________________

Specific directions or information for administration_____________________________________

Special side effects, contraindications, or possible adverse reactions to be observed:
____

Date of order___________ **Discontinuation Date**_________**Diagnosis**________________________

Any other medical conditions or medications?____

Medication____

Route of Administration___________________ **Dosage**__________________________________

Frequency_______________________________ **Time(s) of Administration**___________________

Specific directions or information for administration_____________________________________

Special side effects, contraindications, or possible adverse reactions to be observed:
____

Date of order___________ **Discontinuation Date**_________**Diagnosis**________________________

Any other medical conditions or medications?____

Medication____

Route of Administration___________________ **Dosage**__________________________________

Frequency_______________________________ **Time(s) of Administration**___________________

Specific directions or information for administration_____________________________________

Special side effects, contraindications, or possible adverse reactions to be observed:
____

Date of order___________ **Discontinuation Date**_________**Diagnosis**________________________

Any other medical conditions or medications?____