

## Health History Form for Camp Staff

*\*Because we want to support your ability to do your job well, please complete this form accurately and completely.*

Return Completed Form to

**Maine Teen Camp**  
481 Brownfield Road  
Porter, Maine 04068 USA  
Phone: 207-625-8581  
Fax: 207-625-8738  
Email: [mtc@teencamp.com](mailto:mtc@teencamp.com)

Name: \_\_\_\_\_  
First Name Middle Initial Last Name

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
Month Day Year

Permanent Address: \_\_\_\_\_

Preferred Phone #: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Country of Residence: \_\_\_\_\_

Your Contract Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Your Job Title: \_\_\_\_\_

International Staff: rate your ability to speak English. 0 1 2 3 4 5  
None Good Excellent

- Return this form to our camp office at least four weeks before you arrive. People hired within four weeks of their start date should not send this form ; bring it with you and give it to the director at camp.
- Keep a copy of the completed form for your records; note changes that occur and inform the healthcare provider of these changes.
- Notify the camp director if you are exposed to a communicable disease within three weeks of beginning your job.
- The camp expects that you arrive in good health and capable of doing the job for which you were hired.
- Information on this form is available to Health Center staff and your work supervisor(s).

**Allergies:** Check those that apply to you.

\_\_\_\_\_ I have no known allergies.

\_\_\_\_\_ I have an allergy to this food: \_\_\_\_\_ This causes anaphylaxis?  Yes  No  
Describe what happens if you eat this food and how the reaction is managed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_ I am allergic to this medication/s: \_\_\_\_\_ This causes anaphylaxis?  Yes  No

\_\_\_\_\_ I am allergic to these substances: \_\_\_\_\_ This causes anaphylaxis?  Yes  No  
Describe what happens if you eat this food and how the reaction is managed:

\_\_\_\_\_

\_\_\_\_\_

**Nutrition:** Our expectation is that staff set an example for campers by eating the provided menu. We can work effectively with some medically prescribed diets but cannot cater to individual food preferences. There are times when you might need to simply not eat a served item.

\_\_\_\_\_ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.

\_\_\_\_\_ I am a vegetarian of this type:  Semi-vegetarian (no pork or beef)  Vegan (no meats, eggs or dairy)

Pesco (no pork, beef or chicken)  Lacto-ovo (no beef, pork, chicken, seafood, or fish)

\_\_\_\_\_ I am lactose-intolerant. Be prepared to manage your intolerance using products such as Lactaid or food avoidance.

\_\_\_\_\_ I avoid \_\_\_\_\_ because of religious beliefs. [Insert this if appropriate: Camp kitchens are not kosher.]

\_\_\_\_\_ I respond with an anaphylactic reaction when I eat this food: \_\_\_\_\_

**Chronic Concerns:** Check all that pertain to you and provide information about supportive health care. \*Asthma or Diabetes? Complete additional form available [insert information here].

\_\_\_\_\_ I have no chronic health concerns.

\_\_\_\_\_ I have the following chronic health concern(s):  Asthma\*    Headaches/Migraines    Sleep problem    Diabetes\*  
 Difficult breathing    Dysmenorrhea    Fainting    Surgery history    Seizure disorder: \_\_\_\_\_  
 Back pain or injury    Knee or ankle weakness    Other: \_\_\_\_\_

Provide information about supportive healthcare needed for each checked item:

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**Immunization History:** Provide the month & year for immunizations. Asterisked (\*) immunizations must be current.

Immunization	Date — Month(s) & Year(s)	Immunization	Date — Month(s) & Year(s)
Tetanus Booster*	Current within 10 years:	Polio*	
Varicella* (Chicken Pox)		MMR (Mumps, Measles, Rubella)*	
Meningitis		Pneumococcal	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	DPT (diphtheria, tetanus, pertussis)*	
Hepatitis B		Hepatitis A	
Influenza			

**Medication:** Bring enough medication to last or bring your written prescription to order a refill. Prescription meds MUST be in pharmacy containers with appropriate labels; other remedies must be in original container. International Staff: translate information to English.

\_\_\_\_\_ I do not take medication on a routine basis.

\_\_\_\_\_ I take routine medication (include vitamins) as noted below.

Name of Medication	Reason for Taking It	Dose Given & When	Date Started?
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	

## General Physical History

1. Have you ever been hospitalized?..... Yes No  
Have you ever had surgery? ..... Yes No
2. Have you ever passed out during or after exercise/physical exertion?..... Yes No  
Have you ever been dizzy during or after exercise/physical exertion?..... Yes No  
Have you ever had chest pain during or after exercise/physical exertion? ..... Yes No  
Do you tire more quickly than your friends during exercise/physical exertion?..... Yes No  
Have you ever had high blood pressure? ..... Yes No  
Have you ever been told that you had a heart murmur? ..... Yes No  
Have you ever had racing of your heart or skipped heartbeats? ..... Yes No
3. Do you have skin problems (itching, rashes, acne)?..... Yes No
4. Have you ever been knocked out, fainted, or become unconscious?..... Yes No  
Have you ever had a seizure?..... Yes No  
Have you ever had a stinger, burner, or pinched nerve? ..... Yes No
5. Have you ever had heat or muscle cramps? ..... Yes No  
Have you ever been dizzy or passed out in the heat? ..... Yes No
6. Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of your body areas?  
..... Yes No  
If so, where?  Head  Shoulder  Thigh  Neck  Chest  Forearm  Shin/calf  
 Back  Wrist  Hand  Ankle  Elbow  Knee  Hip  Foot  
Can you lift and carry 30 pounds (14 kilograms) at least ten times without assistance or discomfort? ..... Yes No
7. Have you had chicken pox or are you immunized for chicken pox? ..... Yes No
8. Have you had mononucleosis in the past nine months? ..... Yes No
9. Do you have an uncorrected hearing problem? ..... Yes No  
Do you have an uncorrected vision (sight) problem?..... Yes No  
Do you wear glasses or contacts or use protective eye wear?..... Yes No
10. Do you smoke and/or use other tobacco products? ..... Yes No
11. Do you have any piercings?..... Yes No  
If so, where?  Ears  Eyebrow  Nose  Tongue  Belly Button  Nipple  Other: \_\_\_\_\_
12. Do you have any problems with your teeth?..... Yes No
13. Have you been in countries other than the United States in the past nine months?..... Yes No  
If yes, list the countries and the length of time spent in them.  
Country: \_\_\_\_\_ Dates: \_\_\_\_\_  
Country: \_\_\_\_\_ Dates: \_\_\_\_\_  
Country: \_\_\_\_\_ Dates: \_\_\_\_\_
14. For women: Do you have a menstrual problem (pain, irregularity, etc.)? . . . . . Yes  
No  
Explain and/or provide more detail about the General Physical Health questions to which you responded "yes."  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of your physician: \_\_\_\_\_ Office Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of your dentist/orthodontist: \_\_\_\_\_ Office Phone: (\_\_\_\_\_) \_\_\_\_\_

**Mental & Emotional Health Information**

- A. Have you been diagnosed with attention deficit disorder (ADD) or AD/HD. . . . . Yes No
- B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work? . . . Yes No
- C. Do you have an eating disorder that will impact your work? Type: \_\_\_\_\_ . . . . Yes No
- D. Do you have a learning disability that will impact your work? Type: \_\_\_\_\_ . . . . Yes No
- E. Do you have an emotional health concern that will impact your work? . . . . . Yes No
- F. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?

If "yes" to any question in this section, attach a statement that:

- (a) Describes the concern and your management plan for addressing it while working at camp; and
- (b) Describes the support needed from your work supervisor to compliment your plan. Refer to your job description, available again from camp, if there are questions.

**Paying for Health Care:**

- There is usually no charge for health care provided by the camp's Health Center staff.
- Staff are financially responsible for health care provided by out-of-camp providers.
- If you will be using personal insurance while working at camp, it is your responsibility to know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

**Emergency Contact:** Whom do you want us to contact in an emergency?

First Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to You: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to You: \_\_\_\_\_

**Authorization for Health Care:** Parental signature required for staff less than 18 years of age.

This health history is correct insofar as I know. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp Health Center staff in providing care to me and may be reviewed by work supervisor.

Signature of Staff Person: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent (if needed): \_\_\_\_\_ Date: \_\_\_\_\_



# MEDICAL RECOMMENDATION for CAMP EMPLOYEE

Return this completed form to:

**Maine Teen Camp**  
**481 Brownfield Road**  
**Porter, Maine 04068 USA**

**Ph: 207-625-8581**  
**FAX: 207-625-8738**  
**Email: mtc@teencamp.com**

These medications are stocked in our camp's Health Center and will be used to manage illness and/or injury of this employee.

**CROSS OUT** those that are contraindicated for this person.

- Acetaminophen
- Aloe
- Bismuth Chew Tabs
- Calamine Lotion
- Chlorpheniramine maleate
- Diphenhydramine
- Epinephrine
- Guiafenesin DM
- Hydrocortisone Cream
- Ibuprofen
- Kaopectate
- Cough Drops
- Ivy Dry
- Nix
- Tolnaftate
- Topical Antibiotic Cream
- Pseudoephedrine
- Silver Sulfadiazine

**To Physicians and Their Staff:**

This person is an employee at Maine Teen Camp. The job includes physical activity such as moderate lifting and general play and exertion, and requires the individual to be outside in a variety of weather conditions. Our healthcare staff and the employee's work supervisor use the information provided on this form to guide their interface with the employee. The employee can provide their job's description and list of essential functions to you. If you question the person's suitability for their job, please talk with them about your concerns and develop a plan to address that concern. You can also speak to one of our camp professionals by calling 207-625-8581. Thank you!

Name of Staff Member: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

1. List the chronic health problems of this employee: .....  None

- Asthma       Diabetes
- Allergies       Other: \_\_\_\_\_

2. List the prescription medication(s) this person will take while at camp; provide a medical order for administration.

- None needed while at camp.
- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_

3. List the allergies (food, medication, etc ) of this person .....  No known allergies

- a. \_\_\_\_\_  Intolerance  Anaphylaxis
- b. \_\_\_\_\_  Intolerance  Anaphylaxis
- c. \_\_\_\_\_  Intolerance  Anaphylaxis

*Note: Our expectation is that the employee will have an EpiPen and know how to use it if anaphylaxis is part of the individual's health profile.*

4. Describe other treatments needed by this person to do their job .....  None needed

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. Describe any significant physical findings regarding this person and/or describe any limitations that may impact the employee's job performance.

- No significant findings.
- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. We may have neglected to ask about something you feel is needed to adequately address this person's health needs. If so, please add your comments below.

- No additional comments needed.
- \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Your Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this form, you are telling us that, in your opinion, this person is both physically and emotionally ready to participate as an employee at our camp except as noted in your comments.