Camp Susquehannock Emergency Information and Medical Data Sheet

This form must be completed to provide us with health information to supplement that provided by the staff member's physician on the Camp Susquehannock Medical Form. Completion with signatures on both forms is required for participation in camp. By completing this information, you will help us expedite any situation that might require medical attention. Staff Member's that are minors must gave a custodial parent or guardian sign the form.

STAFF MEMBER

Full Name of Staff Member (Last, First) Nickname (if any) Gender (M/F) Date of Birth

Primary Emergency Contact **Relationship to Staff**

Home Address

Home Phone Work Phone Cell Phone

Email (s) Fax Number

ADDITIONAL

Additional Emergency Contact *(when primary contact cannot be reached)* **Relationship to Staff**

Home Address City State Zip

Home Phone Work Phone Cell Phone

Email (s) Fax Number

INSURANCE

Name of person carrying insurance

Home Address City State Zip

Home Phone Work Phone Cell Phone Fax Number

Social Security Number Name of Employer

Insurance Company Address City State Zip

Policy Number Group Number

Indicate any insurance related telephone calls that must be made before treatment is provided.

MISC

Name of Staff Member's Physician **Address** **Phone**

Name of Staff Member's Dentist **Address** **Phone**

- Staff Members will not participate in camp activities unless this form is **completed and signed.**
- The attached medical form; or equivalent, must be **completed by a licensed heath care provider and attached to this form and sent to camp prior to admittance**.
- The health care provider's examination must have been performed **within the last two years.**

****PLEASE CONTINUE ON REVERSE SIDE****

Camp Susquehannock Medical Data Sheet – Page Two

MEDICAL

Staff Member's Last Name, First **Today's Date**

1. **Does Staff Member have any chronic or current illnesses of which the camp medical staff should be aware?**

   _____

2. **Are there any allergies?**

   Medication ❒ **No** ❒ **Yes** **List:** _____
   Food ❒ **No** ❒ **Yes** **List:** _____
   Bee Sting ❒ **No** ❒ **Yes** **List:** _____
   Other ❒ **No** ❒ **Yes** **List:** _____

   Are any specific medications required to address any of these allergic reactions? If yes, please explain and provide the medication with clearly marked instructions. _____

   _____

3. **If there are any dietary restrictions or issues, please explain what they are:**

   _____

   _____

4. **What medications will the Staff Member need to take while at camp?**

Medication	Dosage	Frequency	Daily or as needed?

All medications must be clearly labeled with the Staff Member's name and the name and strength of the medication. **Cabin counselors may not keep medications on their cabins** except for asthma inhalers. **Cabin counselors must, upon arrival, turn over all other medications to the camp medical staff for administration.** If Staff members require medication that might impair their ability to perform the essential functions of their position, they will discuss the details with Camp Susquehannock Inc.'s medical staff prior to working with campers.

RELEASE

I hereby give permission for me to receive necessary medical care while at camp, including tests and medications. I give permission for camp to release any records required for necessary care and/or for insurance purposes. In case I cannot respond in an emergency, I hereby give permission to the physicians and hospitals selected by camp to administer treatment, including hospitalization.

Signature of Staff Member/Custodial Parent/Guardian **Today's Date**

Camp Susquehannock Medical Form 201_

Report By Licensed Health Care Provider

Full Name of Staff Member (Last, First) Date of Birth

IMMUNIZATION HISTORY

Vaccines	*Date of Initial Series*	*Booster Date*
DPT / TD /Td		
HIB		
Measles/Mumps/Rubella		
Varicella (Chicken Pox)		
Polio		
Hepatitis A		
Hepatitis B		

HEALTH HISTORY

Condition	*Circle No or Yes*		*Describe*
Frequent ear infections	*No*	*Yes*	
Heart defects or disease	*No*	*Yes*	
Seizures	*No*	*Yes*	
Diabetes	*No*	*Yes*	
Bleeding or clotting disorders	*No*	*Yes*	
Hypertension	*No*	*Yes*	
Chicken pox	*No*	*Yes*	
Allergies:			
Food	*No*	*Yes*	
Drugs	*No*	*Yes*	
Allergic rhinitis	*No*	*Yes*	
Asthma	*No*	*Yes*	
Insect stings (systematic reaction)	*No*	*Yes*	
Diarrhea	*No*	*Yes*	
Other	*No*	*Yes*	

HEALTH INFORMATION

Indicate any current treatments and medications to be given at camp. Specify dosage and frequency.			
Are there any play or physical restrictions? Please specify.			
Any dietary restrictions?	*No*	*Yes*	List:
Additional health recommendations:			

Staff Member's Height	Inches	Staff Member's Weight	Lbs.
Blood Pressure		Pulse	

I have examined the above applicant on the date indicated. In my opinion, the above applicant's condition does not preclude him/her from participation in an active camp program.

Licensed Provider's Signature Printed Name of Provider

Address Phone Date of Exam