2019
Staff Health Form

***Because we want to support your ability to do your job well, please complete this form accurately and completely.**
PLEASE PRINT OR TYPE, LEGIBILITY IS VERY IMPORTANT

Return Completed Form to:

Jenny Strong
103 Ent Road
Hanscom AFB, MA 01731

Questions?

Call Jenny at (508) 868-4882 or email pineshorecamp@gmail.com

Name _____
First Name Middle Initial Last Name

Date of Birth_____ Sex _____
Month Day Year

Permanent Address_____

Preferred Phone # (_____)_____ E-mail _____

*__Return this form at least four weeks before your scheduled week at camp.__
*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.

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 and how the reaction is managed:
_____
_____
Do you have a written allergy response plan? ___ Yes ___ No

Nutrition: Check those that apply to you. 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 preference. There are times when you might need to 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)
_____ Pesco (no pork, beef or chicken)
_____ Vegan (no meats, eggs or dairy)
_____ 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 have issues with foods containing gluten based ingredients.

_____ 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.
_____ I have no chronic health concerns.
_____ I have the following chronic health concern(s): ___ Asthma ___ Headaches/Migraines ___ Sleep problem ___Diabetes
___ Difficulty breathing ___ Dysmenorrhea ___ Fainting ___Surgery History ___ Seizure Disorder ___ Back pain or injury
___ Knee or ankle weakness Other: (Please describe)_____

Provide information about supportive healthcare needed for each checked item:
_____
_____
_____

Medication(s): Please complete. 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 over the counter drugs and preparations must be in the original container.

_____ I do not take medication on a routine basis.

_____ I take routine medication(s) (including vitamins) as noted below:

Name of Medication	Reason for Taking It	Dose Given & When	Date Started/Last Dose
		Breakfast Dose _____ Evening Meal Dose _____ Bedtime Dose _____ Other _____	
		Breakfast Dose _____ Evening Meal Dose _____ Bedtime Dose _____ Other _____	
		Breakfast Dose _____ Evening Meal Dose _____ Bedtime Dose _____ Other _____	

The following non-prescription medications are stocked in the Infirmary and can be requested from the Nurse as needed. Those staff members under the age of 18 will need covering consent from parents or guardian.

- Acetaminophen (Tylenol)
- Ibuprofen (Motrin)
- Diphenhydramine (Benadryl)
- TUMS Antacid
- Generic Cough Drops
- Calamine Lotion
- Aloe and Sunscreen
- Neosporin Antibiotic Ointment and Cream
- Hydrocortisone Cream

General Physical History: Please answer all questions.

1. Have you ever been hospitalized? _____ Yes ___ No ___
2. Have you ever had surgery? _____ Yes ___ No ___
3. Have you ever passed out during or after exercise or physical exertion? _____ Yes ___ No ___
4. Have you ever been dizzy during or after exercise or physical exertion? _____ Yes ___ No ___
5. Have you ever had chest pain during or after exercise or physical exertion? _____ Yes ___ No ___
6. Do you tire more quickly than your friends during exercise or physical exertion? _____ Yes ___ No ___
7. Have you ever had high blood pressure? _____ Yes ___ No ___
8. Have you ever been told that you had a heart murmur? _____ Yes ___ No ___
9. Have you ever had racing of your heart or skipped heartbeats? _____ Yes ___ No ___
10. Do you have skin problems (itching, rashes, acne)? _____ Yes ___ No ___
11. Have you ever been knocked out, fainted, or became unconscious? _____ Yes ___ No ___
12. Have you ever had a seizure? _____ Yes ___ No ___
13. Have you ever had a stinger, burner or pinched nerve? _____ Yes ___ No ___
14. Have you ever had heat or muscle cramps? _____ Yes ___ No ___
15. Have you ever been dizzy or passed out in the heat? _____ Yes ___ No ___
16. Have you ever sprained, strained, dislocated, broken, or had repeated swelling or other injuries? _____ Yes ___ No ___
    If so where? _____
17. Can you lift and carry 30 pounds (14 KG) at least ten times without assistance or discomfort? _____ Yes ___ No ___
18. Have you had chicken pox or are you immunized for chicken pox (Varicella)? _____ Yes ___ No ___
19. Have you had mononucleosis in the past nine months? _____ Yes ___ No ___
20. Do you have an uncorrected hearing problem? _____ Yes ___ No ___
21. Do you have an uncorrected vision (sight) problem? _____ Yes ___ No ___
22. Do you wear glasses or contacts or use protective eye wear? _____ Yes ___ No ___
23. Do you smoke and/or use tobacco products or electric cigarettes? _____ Yes ___ No ___
24. Do you have any problems with your teeth? _____ Yes ___ No ___
25. Have you been in countries other than the United States in the past nine months? _____ Yes ___ No ___
    If yes, list the countries and length of time spent in them:
    Country/Dates: _____
    Country/Dates: _____
    Country/Dates: _____
26. For women, Do you have any menstrual problems (cramps, irregularity, etc)? _____ Yes ___ No ___

Please explain and/or provide more detail about the General 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 ADHD)?_____ Yes ___ No ___
b. Do you have a psychiatric diagnosis (e.g. depression, 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 any mental or emotional concerns that will impact your work? Yes ___ No ___

If "yes" to any questions in this section please 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 Pineshore Bible Camp staff to compliment your plan.

Paying for Health Care:

If you have an insurance card either bring it with you to Camp or bring a photocopy (front and back) in the event you need to seek medical treatment while you are at Camp.

Emergency Contact: Who do you want us to contact in an emergency:

First Contact: _____ Relationship to you: _____

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

Alternate Contact: _____ Relationship to you: _____

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

Authorization for Health Care: Signature of parent or guardian 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 Nurse in providing care to me and may be reviewed by my work supervisor.

_____

Staff Person Signature/Date

_____

Parent/Guardian Signature/Date (If needed)

IMPORTANT:

PLEASE ATTACH A COPY OF PHYSICAL AND IMMUNIZATION FORMS. PHYSICAL MUST HAVE BEEN WITHIN THE LAST 24 MONTHS. FORMS WILL NOT BE CONSIDERED COMPLETE WITHOUT THESE AND YOU WILL NOT BE ABLE TO SERVE AT CAMP.

MEDICAL RECOMMENDATION FOR CAMP STAFF- TO BE COMPLETED AND SIGNED BY PHYSICIAN

To Physicians and Their Staff:

Return completed form to:

Jenny Strong
103 Ent Road
Hanscom AFB, MA 01731

Questions/concerns call Jenny @ (508) 868-4882 or email pineshorecamp@gmail.com

Date of last physical (must have been within last 24 months):

_____

Hgt: _____

Wgt: _____

BP: _____

These medications are stocked in our camp's infirmary and will be used to manage illness and/or injuries.
CROSS OUT any meds that are contraindicated for this person:
Acetaminophen
Aloe/Sunscreen
Calamine Lotion
Hydrocortisone Cream
Diphenhydramine
Ibuprofen
Cough Drops
Topical Antibiotic Cream

This person will be a staff member of Pineshore Bible Camp. The job includes physical activity such as lifting, running, and swimming 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 description and list of essential functions if needed. If you question the person's suitability for the job, please talk with them about your concerns and develop a plan to address those concerns. You can also speak to the camp health care coordinator by using the number provided at the left. Thank you!

*****IMPORTANT: PLEASE ATTACH A LIST OF IMMUNIZATIONS THAT THIS PERSON HAS RECEIVED*****

Staff Name: _____ **Date of Birth**: _____

List the chronic health problems for this person_____ None ___
Asthma ___ Allergies ___ Diabetes ___ Other: _____

List the prescription medications this person will be on while at camp. Please provide an order for administration. None needed while at camp ___

a. _____
b. _____
c. _____
d. _____

List the allergies for this person (food, medication, etc.) _____ No known allergies

a. _____ Intolerance ___ anaphylaxis ___
b. _____ intolerance ___ anaphylaxis ___
c. _____ intolerance ___ anaphylaxis ___

Note: Our expectation is that the employee will have an epi pen and know how to use it if anaphylaxis is part of the health profile.

Describe other treatments needed by this person to do their job: _____None needed ___

_____
_____
_____

Describe any significant physical findings regarding this person and/or describe any limitations that may impact the job performance: _____ No significant findings ___

_____
_____
_____

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 ___

_____
_____
_____

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.

_____ _____
Print Name Signature/Date