Camp Chabad Day Camp

Camp Staff Health History

Return to: Camp Chabad
1435 Vine Street
Cincinnati, OH 45202

Please Print and fill out in black ink

Name: Last: _____ First: _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Permanent Address:_____

City: _____ State: _____ Zip: _____

Home Phone:(__ _)_____ Cell: (___)_____ Email: _____

Insurance Carrier or Plan _____Policy/Group # _____

Insurance Co. Phone # (___)_____SS# of policy holder or insurance ID # _____

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

First Contact: _____Phone ( ) _____ Relationship: _____

Alternate Contact: _____Phone ( ) _____ Relationship: _____

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Allergies: Check those that apply to you.

☐ _____ I have no known allergies

☐☐ _____ I have a Food allergy to _____ This causes anaphylaxis? ☐ Yes ☐ No

Describe reaction if this food is eaten and what is done to manage it: _____

_____

_____ I am allergic to Insect stings or other substances _____ This causes anaphylaxis? ☐ Yes ☐ No

Describe reaction and what is done to manage it: _____

_____

_____ I am allergic to this medication/s: _____ This causes anaphylaxis? ☐ Yes ☐ No

Nutrition:

_____ I eat a regular, varied kosher diet.

_____ I am a vegetarian.

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

_____ I respond with an anaphylactic reaction when I eat this food: _____

Other diet concerns: _____

Immunization History: Provide the month and year for immunization. Starred * must be current.

		Dates
	DPT: Piptheria, Tetanus, Pertussis:	_____
*	Td: Tetanus Booster .(must be current within past ten years):	_____
*	MMR: Mumps, Measles, Rubella:	_____
*	Polio:	_____
	Hep B: Hepatitis B:	_____
	Hib: H. influenzae, type b:	_____

Medication:

_____ I do not take medication on a routine basis.

_____ I take routine medication. Medication I take: _____

_____

_____

Name of your Physician: _____ Office Phone: (_____)_____

Name of your Dentist/Orthodontist: _____ Office Phone: (_____)_____

Continued on the back ~~

Health History: Please check all that apply and explain below all that are checked (write # next to explanation)

1._____ Asthma
2._____ Bleeding/clotting Disorder
3._____ Braces/orthodonture device
4._____ Broken bones
5._____ Chronic or recurring illness/condition
6._____ Diabetes
7._____ Diarrhea or constipation
8._____ Disability
9._____ Ear infections
10._____ Eating disorder
11._____ Head injury (e.g.. knocked unconscious, concussion)
12._____ Headaches
13._____ Heart defect/disease (e.g.. heart murmur)
14._____ Hospitalized
15._____ Hypertension
16._____ Migraines
17._____ Mononucleosis
18._____ Seizures
19._____ Serious Injuries
20._____ Skin problems (e.g. itching, rash, acne)
21._____ Surgery
22._____ Wears glasses or contacts
23. _____ Had any recent injury, illness, infectious disease?

Please explain all checked answers, noting the number of the item.: _____
_____
_____
_____
_____

Have you been in countries other than the United States in the past 3 months? ☐ Yes ☐ No
Country: _____ Dates: _____
Country: _____ Dates: _____

Mental and Emotional Health Information: (Describe 'yes' answers below)

Have been diagnosed with Attention Deficit Disorder (ADD) or ADHD ☐ Yes ☐ No
Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder ☐ Yes ☐ No
Do you have and eating disorder? Type: _____ ☐ Yes ☐ No
Do you have a learning disability? Type: _____ ☐ Yes ☐ No
Do you have an emotional health concern? ☐ Yes ☐ No
During the past year, have you seen a professional about mental/emotional health concerns? ☐ Yes ☐ No

_____
_____

Paying for Health Care:
Staff are financially responsible for healthcare provided by physicians or other health care services they visit.
If you have personal insurance while working at camp, it is your responsibility to know how to access that insurance. Bring your insurance card with you; obtain pre-authorization if your insurance requires this.

Authorization for Healthcare: Parental signature required for staff under 18 years of age.
This health history is correct insofar as I know. I am capable of performing the essential functions of my camp job. I understand my health information will be used by the camp's nurse in providing care to me and may be reviewed by the camp director.

Signature of Staff Person: _____ Date:_____
Signature of Parent (if needed): _____Date: _____

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Screening Record (For camp use only) Screened by: _____

Date screened: _____ Updates/additions to health history noted ☐ Yes ☐ No ☐ None required
Health needs noted: _____
Any signs/symptoms of head lice? ☐ Yes ☐ No _____
Notes: _____
_____