



**PLEASE RETURN TO:**

**WINTER** (September 1 - May 31)  
3 New King St., White Plains, NY 10604  
p: 914-437-7200 f: 914-422-3635

**SUMMER** (June 1 - August 31)  
700 Churchill Street, Pittsfield, MA 01201  
p: 413-447-8900 f: 413-447-8905

# STAFF HEALTH HISTORY FORM

**TO BE COMPLETED BY EMPLOYEE**

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
First Name Middle Initial Last Name 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 Health Center staff 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. 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.

\_\_\_\_\_ 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
- 2. Have you ever had surgery? ..... Yes No
- 3. Have you ever passed out during or after exercise/physical exertion? ..... Yes No
- 4. Have you ever been dizzy during or after exercise/physical exertion? ..... Yes No
- 5. Have you ever had chest pain during or after exercise/physical exertion? ..... Yes No
- 6. Do you tire more quickly than your friends during exercise/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 become 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, 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

- 17. Have you had chicken pox or are you immunized for chicken pox? ..... Yes No
- 18. Have you had mononucleosis in the past nine months? ..... Yes No
- 19. Do you have an uncorrected hearing problem? ..... Yes No
- 20. Do you have an uncorrected vision (sight) problem? ..... Yes No
- 21. Do you wear glasses or contacts or use protective eye wear? ..... Yes No
- 22. Do you smoke and/or use other tobacco products? ..... Yes No
- 23. Do you have any piercings? ..... Yes No

If so, where?  Ears  Eyebrow  Nose  Tongue  Belly Button  Nipple  Other: \_\_\_\_\_

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 the length of time spent in them.

Country: \_\_\_\_\_ Dates: \_\_\_\_\_

Country: \_\_\_\_\_ Dates: \_\_\_\_\_

Country: \_\_\_\_\_ Dates: \_\_\_\_\_

26. 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.

**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 and use that insurance. If your insurance requires pre-authorization, you should consider obtaining it prior to arriving at camp. **Make sure to bring your insurance card to camp AND attach a copy to this form.**

**Medical Insurance Information:**

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Company Phone Number \_\_\_\_\_

**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: \_\_\_\_\_