CLOVER PATCH CAMP

Employee Medical and Health History Forms

GENERAL INFORMATION

1. Forms A and B must completed and returned to the camp office prior to May 1st. We ask that you send it prior to arrival so that we may review the information for completeness. Since you will be working with a vulnerable population a complete health history and record of immunizations is imperative.
2. Form A – *Employee Medical Form* should be completed by a licensed physician.

   Form B – *Employee Health History Form* should be completed by the employee.
3. Keep a copy of the completed forms for your records.
4. If you are unable to receive the PPD test prior to arriving, the test can be performed upon arrival at camp at no charge.
5. Notify the camp director immediately if you are exposed to a communicable disease within 21 days of your arrival.
6. We expect you to arrive in good health and capable of doing the job for which you were hired.
7. Information on this form will be kept strictly confidential and will only be available to camp healthcare providers and camp administrators.
8. For your convenience the form may be completed in Word and printed for signature. Return the forms via fax [518-384-3001] or mail to the camp address. Scanned forms may be emailed to *d_ross@cfdsny.org*.

PAYING FOR HEALTH CARE

1. There is no charge for healthcare administered by camp healthcare providers. Beyond initial treatment the employee may be asked to purchase over-the-counter medications, ointments, etc. for continued treatment.
2. The employee is financially responsible for health care provided by out-of-camp providers (Ellis Hospital/Urgent Care Clinic), unless otherwise specified.
3. 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.

CLOVER PATCH CAMP

Form A - Employee Medical Form

(To be completed by a licensed physician.)

Name: ______________________________ Date of Birth: ______________

This individual is an employee at Clover Patch Camp. The job duties include physical activity that is vigorous and requires the individual to be subject to a variety of environmental influences such as inclement weather, insects, heat, etc. Please complete the following form and return it to the individual.

IMMUNIZATIONS [Please give all dates of inoculation or attach a copy of the vaccination record.]

Tetanus	Date of inoculation:
Measles/Mumps/Rubella (MMR) ◆ **Measles** (2 required; Must be after 1968.) ◆ **Rubella** (Must be after 1969.) ◆ **BCG** *or* ◆ **Combined as 2 MMRs** (Must be after 1972.)	Dates of inoculation: 1. ______________ 2. ______________
PPD (Tuberculin test) ◆ Results must be dated with one year of the last day of employment. If positive, a chest x-ray report or a note from physician is required stating that the individual is asymptomatic. ◆ *If unable to receive this test prior to arriving, the test can be performed at camp.*	Date of Test: ______________ Given by: ______________ Date of Reading: ______________ Read by: ______________ Results: ☐ Positive ☐ Negative

SYSTEMS REVIEW

Height: _____ Weight: _____ Pulse: _____ BP: _____ Respiration: _____

Please ✓ if within normal limits.

WNL	System	Notes
☐	General Appearance	
☐	Abdomen	
☐	Chest-lungs	
☐	Ears/Hearing	
☐	Eyes/Vision	
☐	Heart	
☐	Neck/Thyroid	

CLOVER PATCH CAMP

Form A - Employee Medical Form

(To be completed by a licensed physician.)

Name: ______________________________ Date of Birth: ______________

MEDICAL HISTORY

Chronic Health Problems	
Recent Illnesses	
Operations/Injuries	

MEDICATIONS

Will this individual take any prescription medication(s) while at camp? ☐ NO ☐ YES

If yes, please list medication(s) and purpose.

____

____

ALLERGIES

Does this individual have allergies (food, medication, environmental, etc.)? ☐ NO ☐ YES

If yes, please comment.

____

____

RECOMMENDATIONS / RESTRICTIONS WHILE AT CAMP

____

____

I have examined this individual and have reviewed his/her medical history. It is my opinion that he/she is physically able to participate in camp activities at Clover Patch Camp, except as noted above.

______________________	______________________	__________
Physician Signature	**Physician Name (print)**	**Date**

CLOVER PATCH CAMP

Form B - Employee Health History Form

(To be completed by the employee.)

Name: ______________________________ Date of Birth: ______________

NUTRITION (Please check all that apply.)

- ☐ I eat a regular diet.
- ☐ I am a vegetarian. (Vegetarian options are provided at each meal.)
- ☐ I am a vegan. (Employees are expected to provide and prepare their own meals.)
- ☐ I am lactose-intolerant. (Employees are expected to provide their own soy milk, Lactaid, etc.)
- ☐ I have the following food allergies. ______________________________
- ☐ Other ______________________________

HEALTH STATUS ASSESSMENT

1. In the past year:
   a. Have you been hospitalized? ☐ NO ☐ YES
   b. Have you had surgery? ☐ NO ☐ YES
   c. Have you had any illnesses? ☐ NO ☐ YES
   d. Have you had any work-related injuries? ☐ NO ☐ YES
   e. Have you had any changes in the way you feel? ☐ NO ☐ YES
2. Are you taking any prescription medication(s)? ☐ NO ☐ YES
3. Are you taking any over-the-counter medication(s) on a regular basis? ☐ NO ☐ YES
4. Do you have any allergies (medication, food, environmental)? ☐ NO ☐ YES
5. Are you unable to lift 50 pounds regularly? ☐ NO ☐ YES
6. Do you have an uncorrected hearing problem? ☐ NO ☐ YES
7. Do you wear glasses or contacts? ☐ NO ☐ YES
8. Do you smoke and/or use other tobacco products? ☐ NO ☐ YES
9. Do you have any piercings? ☐ NO ☐ YES
   Are you willing to remove them for your safety and the safety of the campers? ☐ NO ☐ YES
10. Do you have any visible tattoos? ☐ NO ☐ YES
    Are you willing to cover them, if requested? ☐ NO ☐ YES

Please explain all “yes” answers. ______________________________

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MENTAL & EMOTIONAL HEALTH INFORMATION

1. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work? ☐ NO ☐ YES
2. Do you have an emotional health concern that will impact your work? ☐ NO ☐ YES
3. Do you have an eating disorder that will impact your work? ☐ NO ☐ YES
4. Do you have a learning disability that will impact your work? ☐ NO ☐ YES

Please explain all “yes” answers. ______________________________

____

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CLOVER PATCH CAMP

Form B - Employee Health History Form

(To be completed by the employee.)

Name: ____ Date of Birth: __________________

EMERGENCY CONTACTS

Contact #1

Name: _________________________________ Relationship to Employee: _______________________

Phone Number: __________________________ Alternate Phone Number: _______________________

Contact #2

Name: _________________________________ Relationship to Employee: _______________________

Phone Number: __________________________ Alternate Phone Number: _______________________

Contact #3

Name: _________________________________ Relationship to Employee: _______________________

Phone Number: __________________________ Alternate Phone Number: _______________________

CONSENT AND WAIVER

Consent to Treat

In the event of an emergency, I give my consent for Clover Patch Camp Healthcare Providers or Ellis Hospital/Urgent Care Clinic to administer treatment and to conduct any tests required to render necessary medical care.

Waiver

a. I am capable of performing the essential functions of my job and can participate in assigned work duties.

b. I agree to notify the Camp Director immediately if I have been exposed to a contagious disease within 21 days of the date I am to report to Camp.

c. All the information provided is accurate and complete.

I have read, understand and consent to the above.

____ __________________________

Employee Signature **Date**