Summer Camps at College Settlement

600 Witmer Road Horsham, PA 19044 Phone: 215-542-7974

Staff Medical Form 2018

Mail this form by: _____

THIS PAGE AND TOP HALF OF BACK TO BE COMPLETED BY STAFF MEMBER:

STAFF INFORMATION:

Last Name: _____ First Name: _____ Date of Birth: ___/___/_____

Gender: ☐ Male ☐ Female Social Security Number: __ __ __ - __ __ - __ __ __ __

Home Address: _____ Apt #_____

City: _____ State: _____ Zip:_____ Home Phone: _____

Cell: _____

PLEASE LIST TWO PEOPLE WHO COULD BE CONTACTED IN CASE OF EMERGENCY:

Emergency Contact 1:_____ Relationship to Staff Member: _____

Home Phone: _____ Cell: _____ Work: _____

Emergency Contact 2:_____ Relationship to Staff Member: _____

Home Phone: _____ Cell: _____ Work: _____

INSURANCE INFORMATION

Are you covered by health insurance? ☐ Yes ☐ No

If so, indicate name of insurance plan _____Group Number_____

Insurance Plan's address _____

Name of Plan Holder_____ Relationship to Staff Member:_____

Insurance ID number or social security number of plan holder _____

**********IMPORTANT: THIS BOX MUST BE COMPLETED **********

Permission to Provide Necessary Treatment or Emergency Care: I hereby give my permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. In an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization. This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities except as noted.

♥ Signature of Staff Member _____

Printed Name _____Date _____

TO BE COMPLETED BY STAFF MEMBER:

HEALTH HISTORY: The following information must be filled in. Any changes to this form should be provided to camp health personnel upon participant's arrival in camp.

Do you have any health problems that could prohibit you from participating in camp activities? □ Yes □ No

Are you currently under the care of a physician? □ Yes □ No

Please Explain _____

Do you have any dietary, medical or physical restrictions or allergies (food, medications, contact allergies) ? □ Yes □ No If yes, please list: _____

Do you take any prescription medications? □ Yes □ No

	Name of Medication	Purpose	Dosage	When
1.				
2.				
3.				

Are you "up to date" on your immunizations? □ Yes □ No

(INTERNATIONAL STAFF ONLY: please submit a copy of your immunization records)

Use this space to provide any additional relevant information about yourself which the camp should be aware such as, ear plugs, Sleep disorders. fears/phobias, etc. Please explain.

The below information is not required for employment however we recommend it be complete along with a required copy of your immunization records.

THE FOLLOWING TO BE COMPLETED BY LICENSED MEDICAL PERSONNEL:

I have examined the above camp employee. Date of examination _____

BP _____ Weight _____ Height _____

In my opinion, the above applicant □ is □ is not able to participate in an active camp program.

The applicant is under the care of a physician for the following conditions:

_____

_____

Current treatment at the time of this report includes:

_____

_____

Recommendations And Restrictions At Camp:

Treatment to be continued at camp

_____

_____

Medications to be administered a camp_____

Any restrictions while at camp, either dietary or physical? _____

_____

Additional Information for health care staff at camp

_____

_____

Signature of Licensed Medical Personnel _____Date _____

Printed _____ Title _____

Address _____ Phone _____