SYJCC 74 HAUPPAUGE RD. COMMACK, NY 11725 (631) 462-9800

STAFF HEALTH INFORMATION FORM

(Note: To be completed, **notarized** and returned to SYJCC office 1 month before the start of camp.)

Staff Last Name	**First Name**	Sex	Date of Birth	Age	Grade (as of Sept.)
_____	_____	____	_____	___	_____

Address_____Town//Zip_____Home Phone _____

Parent/Guardian #1:_____ __Work Number: _____Cell Phone:_____

Parent/Guardian#2:_____WorkNumber:_____CelPhone:_____

Email Address:_____

Emergency Name #1 _____ Emergency Phone_____

Emergency Name # 2 _____ Emergency Phone _____

Family Physician, Name_____Telephone Number_____

HEALTH HISTORY: (Check - give approximate dates)

____Frequent Colds_____Abscessed Ears ____Fainting_____Stomach Upsets_____Athlete's Foot ____Sinusitis
____T.B._____Bronchitis _____Motion Sickness_____Convulsions_____Whooping Cough_____ Polio
____ Poison Ivy ___Rheumatic Fever_____Heart Trouble ____ Diabetes_____ Poison Oak/Sumac

Has daughter menstruated? _____ Has she been told about it? _____
Operations, Serious illnesses or injury, explain._____
Any specific activities to be encouraged_____
Any specific activities to be restricted_____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. If camper needs medication during camp hours, keep it in the original packaging/bottle that identifies the prescribing physician, the name of the medication, the dosage, and the frequency of administration. A doctor's note and Parent's note will also be required.

☐This person **takes NO medications** on a routine basis. Or ☐This person **takes medications** as follows:
Med #1 _____Dosage_____Specific times taken each day_____
Reason for taking _____
Med #2 _____ Dosage _____Specific times taken each day_____
Reason for taking_____
Attach additional pages for more medications.
Identify any medications taken during the school year that participant does/may not take during this summer_____

IMPORTANT: Please notify the camp if your child was exposed to any communicable diseases during the **3 weeks prior** to camp attendance.

AUTHORIZATION FOR EMERGENCY MEDICAL SURGICAL TREATMENT

NOTE: It is the firm hope that the authorization granted on this form will never have to be used. However, for the safety of your child, sound medical practice calls for such authorization. In emergency situations where for some reason, the parent cannot be contacted immediately, this form may be extremely important. Doctors and hospitals refuse to give any treatment, regardless of how minor, unless they have a notarized authorization from a parent.

THE AUTHORIZATION GRANTED BY THIS FORM WILL BE USED ONLY WHEN ABSOLUTELY NECESSARY AND ONLY AFTER EVERY ATTEMPT HAS BEEN MADE TO CONTACT A PARENT.

I understand that in the event I cannot be reached, I hereby give permission to the physician or hospital selected by the SYJCC camp administration to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child, as named above.

_____ _____
Signature of Staff Member. If under 18, Parent or Guardian **Date**
(Must sign in front of notary)

Notary: _____ _____
Date

(Please have your physician fill out and sign the reverse side of this form before returning it to the SYJCC Office. Thank you.)

PHYSICAL EXAMINATION

Staff Name_____

Date of Examination_____ (To be completed by a Licensed Physician)

Code:_____ Satisfactory: _____ Not Satisfactory(please explain) _____

Hgt. _____ Blood Pressure _____ Eyes _____ Glasses? _____Wgt. _____

Hgb. Test Done: _____Urine Analysis Test Done?_____Ears _____ Extremities _____

Nose _____Posture (spine) _____Throat _____ Skin _____ Heart _____

Genitalia_____General Appraisal:_____

Lungs _____ Hernia _____ Abdomen _____ Menstrual History _____

Recommendations and/or restrictions (diet, medicine, swimming, diving, etc.)_____

_____

ALLERGIES List all known. Describe reaction and management of the reaction.

Medication Allergies (list)

_____ _____

_____ _____

Food Allergies (list)

_____ _____

_____ _____

Other Allergies (list) - include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

IMMUNIZATIONS: **PLEASE ENTER DATES (State law requires dates to be entered)**

Which of the following has the participant had?	Please give all dates of immunization for: Vaccine:	Dates: Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr	Mo/Yr
☐ Measles	DTP	_____	_____	_____	_____	_____	_____
☐ Chicken pox	TD(tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
☐ German measles	Tetanus	_____	_____	_____	_____	_____	_____
☐ Mumps	Polio	_____	_____	_____	_____	_____	_____
☐ Hepatitis A	MMR	_____	_____	_____	_____	_____	_____
☐ Hepatitis B	Or Measles	_____	_____	_____	_____	_____	_____
☐ Hepatitis C	Or Mumps	_____	_____	_____	_____	_____	_____
	Or Rubella	_____	_____	_____	_____	_____	_____
TB Mantoux test	Haemophilus influenza B	_____	_____	_____	_____		
Date of last test_____	Hepatitis B	_____	_____	_____			
Result: ☐ Positive ☐ Negative	Varicella (chicken pox)		_____	_____			

_____ _____

Signature of Examining Physician

_____ _____

Telephone Number

_____ _____

Date of Examination

Physician's Stamp

(Reverse side to be completed)