

Camp Susquehannock Emergency Information and Medical Data Sheet

This form must be completed to provide us with health information to supplement that provided by the staff member's physician on the Camp Susquehannock Medical Form. Completion with signatures on both forms is required for participation in camp. By completing this information, you will help us expedite any situation that might require medical attention. Staff Member's that are minors must give a custodial parent or guardian sign the form.

STAFF MEMBER	<hr/>			
	Full Name of Staff Member (Last, First)	Nickname (if any)	Gender (M/F)	Date of Birth
	Primary Emergency Contact		Relationship to Staff	
	<hr/>			
	Home Address			
<hr/>		<hr/>		
Home Phone		Work Phone	Cell Phone	
<hr/>				
Email (s)			Fax Number	
ADDITIONAL	Additional Emergency Contact <i>(when primary contact cannot be reached)</i>		Relationship to Staff	
	<hr/>			
	Home Address	City	State	Zip
	<hr/>		<hr/>	
	Home Phone	Work Phone	Cell Phone	
<hr/>				
Email (s)			Fax Number	
INSURANCE	Name of person carrying insurance			
	<hr/>			
	Home Address	City	State	Zip
	<hr/>		<hr/>	
	Home Phone	Work Phone	Cell Phone	Fax Number
	<hr/>		<hr/>	
	Social Security Number	Name of Employer		
<hr/>		<hr/>		
Insurance Company	Address	City	State	Zip
<hr/>		<hr/>		
Policy Number	Group Number			
<hr/>				
Indicate any insurance related telephone calls that must be made before treatment is provided.				
MISC	Name of Staff Member's Physician		Address	Phone
	<hr/>		<hr/>	<hr/>
	Name of Staff Member's Dentist		Address	Phone
<hr/>		<hr/>	<hr/>	

- ◆ Staff Members will not participate in camp activities unless this form is **completed and signed**.
- ◆ The attached medical form; or equivalent, must be **completed by a licensed health care provider and attached to this form and sent to camp prior to admittance**.
- ◆ The health care provider's examination must have been performed **within the last two years**.

****PLEASE CONTINUE ON REVERSE SIDE****

Camp Susquehannock Medical Data Sheet – Page Two

MEDICAL

Staff Member's Last Name, First

Today's Date

1. Does Staff Member have any chronic or current illnesses of which the camp medical staff should be aware?

2. Are there any allergies?

- Medication No Yes List: _____
- Food No Yes List: _____
- Bee Sting No Yes List: _____
- Other No Yes List: _____

Are any specific medications required to address any of these allergic reactions? If yes, please explain and provide the medication with clearly marked instructions. _____

3. If there are any dietary restrictions or issues, please explain what they are:

4. What medications will the Staff Member need to take while at camp?

Medication	Dosage	Frequency	Daily or as needed?

All medications must be clearly labeled with the Staff Member's name and the name and strength of the medication. **Cabin counselors may not keep medications on their cabins** except for asthma inhalers. **Cabin counselors must, upon arrival, turn over all other medications to the camp medical staff for administration.**

RELEASE

I hereby give permission for me to receive necessary medical care while at camp, including tests and medications. I give permission for camp to release any records required for necessary care and/or for insurance purposes. In case I cannot respond in an emergency, I hereby give permission to the physicians and hospitals selected by camp to administer treatment, including hospitalization.

Signature of Staff Member/Custodial Parent/Guardian

Today's Date

Camp Susquehannock Medical Form 2012
Report By Licensed Health Care Provider

Full Name of Staff Member (Last, First)

Date of Birth

IMMUNIZATION HISTORY		
<i>Vaccines</i>	<i>Date of Initial Series</i>	<i>Booster Date</i>
DPT / TD /Td		
HIB		
Measles/Mumps/Rubella		
Varicella (Chicken Pox)		
Polio		
Hepatitis A		
Hepatitis B		

HEALTH HISTORY			
<i>Condition</i>	<i>Circle No or Yes</i>		<i>Describe</i>
Frequent ear infections	<i>No</i>	<i>Yes</i>	
Heart defects or disease	<i>No</i>	<i>Yes</i>	
Seizures	<i>No</i>	<i>Yes</i>	
Diabetes	<i>No</i>	<i>Yes</i>	
Bleeding or clotting disorders	<i>No</i>	<i>Yes</i>	
Hypertension	<i>No</i>	<i>Yes</i>	
Chicken pox	<i>No</i>	<i>Yes</i>	
Allergies:			
Food	<i>No</i>	<i>Yes</i>	
Drugs	<i>No</i>	<i>Yes</i>	
Allergic rhinitis	<i>No</i>	<i>Yes</i>	
Asthma	<i>No</i>	<i>Yes</i>	
Insect stings (systematic reaction)	<i>No</i>	<i>Yes</i>	
Diarrhea	<i>No</i>	<i>Yes</i>	
Other	<i>No</i>	<i>Yes</i>	

HEALTH INFORMATION			
Indicate any current treatments and medications to be given at camp. Specify dosage and frequency.			
Are there any play or physical restrictions? Please specify.			
Any dietary restrictions?	<i>No</i>	<i>Yes</i>	List:
Additional health recommendations:			
Staff Member's Height	Inches	Staff Member's Weight	Lbs.
Blood Pressure		Pulse	

I have examined the above applicant on the date indicated. In my opinion, the above applicant's condition does not preclude him/her from participation in an active camp program.

Licensed Provider's Signature

Printed Name of Provider

Address

Phone

Date of Exam