



CAPE COD SEA CAMPS

2009 Staff Health Form

Return **BEFORE ARRIVING** at Camp or by **JUNE 1** to
Cape Cod Sea Camps
PO Box 1880
Brewster, MA 02631
FAX 508 896 8272

- Completed form must be in our office (address above) PRIOR TO ARRIVAL at camp or by June 1.
- It is a requirement of the Commonwealth of Massachusetts that all seasonal employees have a completed physical exam prior to working with children.
- If under the age of 21, the form must be signed by a custodial parent/guardian.
- Cape Cod Sea Camps requires that all staff provide documentation of a physical examination by a health care provider within twenty-four months preceding the opening of camp.
- Keep a copy of the completed form; notify our health care service of changes in writing.
- Our healthcare and leadership staff have access to this information.
- Questions? Call the Health Center or camp at 508 896 3451



**Staff and/or Parents Please
Complete
Pages 1 – 4**

**Health Care Provider Completes
Pages 5-6**

**Return Health Form by
JUNE 1**

Family Information

Staff Name _____
Last First Middle

Male Female Age as of 6/15: _____ Birth Date _____
Month Day Year

If under 21 years of age, Custodial Parent/ Guardian: (circle one)
BOTH PARENTS FATHER MOTHER OTHER _____

Staff Address:
HOME Address _____

City _____ State _____

Zip _____ Country _____

Home Tel. _____ Business Tel. _____

Cell Tel. _____ FAX/email _____

SUMMER Address _____

City _____ State _____

Zip _____ Country _____ Summer Tel _____

Parent(s)/Guardian/Spouse/Significant Other:
Name _____

HOME Address _____

City _____ State _____

Zip _____ Country _____

Home Tel. _____ Business Tel. _____

Cell Tel. _____ FAX/email _____

SUMMER Address _____

City _____ State _____

Zip _____ Country _____ Summer Tel _____

Emergency Contacts: If we cannot reach your parent/guardian in an emergency, provide contact information for other people with whom we can consult. We assume you have spoken to these emergency contacts and they are willing to assist if the need arises.

1. Name _____ Telephone _____

2. Name _____ Telephone _____

****Parent/Guardian (if under 21) or STAFF Must Complete The Following For Attendance****

EMERGENCY CARE AUTHORIZATION FOR HEALTH CARE

This health history is correct and accurately reflects the health status of the individual to which it pertains. I hereby give permission to the medical personnel selected by Cape Cod Sea Camps:

- To order X-rays, routine diagnostic tests, treatment;
- To release any records necessary for treatment, referral, billing, or insurance purposes; and
- To provide or arrange necessary related transportation for me.

In the event my parent/guardian/spouse cannot be reached in an emergency or I am unable to respond, I hereby give permission to the physician selected by Cape Cod Sea Camps to secure and administer treatment, including hospitalization, for the person named above. I understand the information on this form will be shared on a "need to know" basis with the Cape Cod Sea Camps staff. I give permission to photocopy this form for use out of camp. In addition, Cape Cod Sea Camps has permission to obtain a copy of my health record from providers who treat me and these providers may talk with the Cape Cod Sea Camps' staff about my health status.

VALIDATION OF HEALTH HISTORY AND PERMISSION TO ENGAGE IN ACTIVITIES

I do hereby confirm that the health information provided for the individual identified above is accurate and honest. Therefore, the person herein described has permission to engage in all prescribed camp activities except as noted. ***If for religious reasons you cannot sign this, camp should be contacted for a legal waiver.**

Signature of staff or, if under 21, custodial parent/ guardian _____
Date _____

Name: _____

Health Care Providers and Insurance

Medical Health Insurance coverage is required for each staff.

Name of Primary Care Provider _____ Tel _____
 Name of Dentist/Orthodontist _____ Tel _____
 Health Insurance Company _____ Tel _____
 Name of Policy Holder _____ Policy Number _____ Group Name/Number _____

Health History – STAFF Complete

Allergies: Check all that apply. Attach additional information on separate sheet if needed.

- This individual has **NO KNOWN ALLERGIES**.
- This individual is **ALLERGIC** to this **FOOD(s)**: _____
 Causes *anaphylaxis? YES NO
 Describe typical reaction _____
 Describe treatment _____
- This individual is **ALLERGIC** to this **MEDICATION(s)**: _____
 Causes *anaphylaxis? YES NO
 Describe typical reaction _____
 Describe treatment _____
- This individual is **ALLERGIC** to the following, e.g. environmental, animals, etc.: _____
 Causes *anaphylaxis? YES NO
 Describe typical reaction _____
 Describe treatment _____

Nutrition: Check all that apply. Our kitchen prepares a menu with variety; be sure you are ready to explore various foods. We can work with some medically prescribed diets but do not cater to individual food preferences. Call if you have questions.

- This individual eats a regular diet.
- This individual is the following type of vegetarian.
 Semi-vegetarian (no pork or beef) Pesco (no pork, beef or chicken)
 Lacto-ovo (no beef, pork, chicken, seafood or fish) Vegan (no meats, seafood, eggs or dairy)
- This individual does not eat pork because of faith beliefs.
- This individual is lactose intolerant. Note: our expectation is that the employee self-manages using products such as Lactaid.
- This individual has Celiac Disease. Note: our expectation is the employee will speak with the Food Service Manager regarding specific diet.

Chronic or Life-Threatening Health Concerns: Check all that apply.

- This individual has **NO CHRONIC** or **LIFE-THREATENING** health concerns.
- This individual has the following **CHRONIC** health concerns. Attach additional information if needed.

Health Concern	Comments – Treatments & approximate dates	Health Concern	Comments – Treatments & approximate dates
<input type="checkbox"/> Asthma/Respiratory Disorder _____		<input type="checkbox"/> Frequent Colds _____	
<input type="checkbox"/> Bedwetting _____		<input type="checkbox"/> Frequent Ear Infections _____	
<input type="checkbox"/> Bleeding Disorder _____		<input type="checkbox"/> Headaches _____	
<input type="checkbox"/> Cardiac Disorder _____		<input type="checkbox"/> Hospitalizations/Surgery _____	
<input type="checkbox"/> Chronic Illness _____		<input type="checkbox"/> Metabolic Disorder/Diabetes _____	
<input type="checkbox"/> Digestive Disorder/Diet Restriction _____		<input type="checkbox"/> Neurological Disorder/Seizures _____	
<input type="checkbox"/> Eating Disorder/Compulsions _____		<input type="checkbox"/> Orthopedic Disorder/Activity Restriction _____	
<input type="checkbox"/> Encopresis/Constipation _____		<input type="checkbox"/> Throat Disorder/Speech Deficit _____	
<input type="checkbox"/> Fainting _____		<input type="checkbox"/> Other _____	

Name: _____

***Immunizations:** Please record the dates (month/year) of basic immunizations and most recent booster.

Immunizations	Date(s): Month(s) & Year(s)					
DPT (Diphtheria, Pertussis, Tetanus)						
Td (Tetanus)						
OPV/IPV (Polio)						
MMR (Measles, Mumps, Rubella)						
Hib (Haemophilus Influenza Type B)						
Hepatitis B						
PPD/Mantoux (Tuberculosis)						
Varicella (chicken pox)						
Meningitis						
Other						

*If you have not been immunized, please explain why and/or attach supporting documentation. _____

General History: Check "True" or "False" for each statement.

- This individual has had chicken pox or has received varicella immunization..... True False
- This individual has NOT had MONONUCLEOSIS ("Mono") during the past year..... True False
- This individual's HEARING is within normal ranges..... True False
- This individual's EYESIGHT is within normal ranges or he/she uses corrective lenses to remedy vision..... True False
- This individual typically sleeps without SLEEPWALKING, SNORING, SLEEP TALKING, or making other noises..... True False
- This individual is free of illness, injury or physical challenges that would effect program participation..... True False
- This individual has been in countries OUTSIDE THE UNITED STATES in the past nine (9) months..... True False

If "True", list the countries and the length of time spent in each.

Country _____ Country _____
 Dates _____ Dates _____

Mental, Emotional and Social Health: Check "Yes" or "No" for each statement.

- This individual has been diagnosed with Attention Deficit Disorder (ADD) or AD/HD..... Yes No
- This individual has a psychiatric diagnosis such as depression, OCD, panic/anxiety disorder..... Yes No
- This individual has an emotional health concern (specify _____) Yes No
- During the past year, this individual has seen or is currently seeing a professional to address mental/emotional concerns..... Yes No

If "yes" was the answer to any of the four statements above, attach a statement from your professional (e.g. psychiatrist, physician) that addresses the following three things:

- Describes the concern and the management plan (including medication) while in our program;
- Describes the behaviors that will indicate to our medical staff that you may need a professional referral; and,
- Provides a recommendation for the individual's participation in the Cape Cod Sea Camps program.

- This individual has had a significant life event that continues to affect their life Yes No

If "yes", please provide written information about the event – death of a loved one, adoption, new sibling, survived a disaster – it's impact upon your life.

Physical Examination Completed by a Licensed Provider

I have examined (Patient's Name) _____ on (Date of Exam) _____.

This patient will be employed at either a summer overnight/residential or day program of Cape Cod Sea Camps (CCSC). The program includes physical activity (i.e. swimming, sailing, soccer, tennis, etc.) and takes place outdoors. CCSC requires that all staff provide documentation of a physical examination within the twenty-four (24) months preceding the opening of camp. In order to provide proper health supervision while at camp, we ask that the licensed provider advise us of any health concerns, allergies, diet and activity restrictions. Please be specific and attach additional information on a separate sheet if necessary.

Height _____ Weight _____ Pulse _____ Respirations _____ Blood Pressure _____

Please indicate, "YES" if patient's examination is *within normal limits* or "NO" if exam is *of concern*. If "NO" is checked, please describe condition.

SYSTEM	YES	NO	COMMENT
General Appearance			
Skin			
Eyes/Vision			
Ears/Hearing			
Nose			
Mouth/Teeth			
Cardiovascular			
Lungs			
Abdomen			
Genitourinary			
Musculoskeletal			
Neurologic			
Development			
Other			

➤ The patient is under the care of a physician for the following reason(s): _____

➤ Describe the treatment(s) to be continued at CCSC for this patient: _____

ALLERGY HISTORY

➤ This patient has allergies. If "yes", please document allergy, typical response and treatment plan below..... YES NO

ALLERGEN	Typical Reaction	Treatment Plan

RECOMMENDATIONS WHILE AT CAMP

➤ This patient DOES HAVE ACTIVITY RESTRICTIONS..... YES NO
Describe _____

➤ This patient DOES HAVE DIETARY RESTRICTIONS..... YES NO
Describe _____

➤ This patient WILL RECEIVE MEDICATIONS while at camp..... YES NO
(Prescription and/or Over-the-Counter) If "YES", please complete the attached Medication Authorization Form (page 5).
Please use one form per medication.

➤ **ADDITIONAL INFORMATION:** We would appreciate any additional information you may have that would help us to provide optimal care for this individual. Attach a separate sheet for additional information, if necessary.

VALIDATION OF EXAMINATION

In my opinion the above individual may participate in an active camp program with noted restrictions.



Licensed Provider Signature (MD/NP) _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Country _____ Office Telephone _____ Fax _____

CAPE COD SEA CAMPS 2009

PO Box 1880, Brewster, MA 02631
Telephone: (508) 896-3451 FAX: (508) 896-8272

CAPE COD SEA CAMP'S MEDICATION AUTHORIZATION FORM

Licensed Provider and Parent/Guardian Responsibility for Prescription Medication, Non-Prescription Medication and/or Food Supplements

- All medications including prescription and over-the-counter medications are NOT allowed in camper cabins.**
- All medications including prescription, over-the-counter medications, allergy injections, food supplements and vitamins shall have a completed Medication Authorization Form on file in order to be administered while at camp at the camp health center. **One form must be completed for each medication.**
- All medications shall be authorized by signature by a licensed provider.
- All prescription and over-the-counter medications must be received in a properly labeled pharmacy prescription container bearing a current date, appropriate patient's name, drug name, and the prescribing licensed provider's name, as well as the prescribed dosage and administration time or over-the-counter packaging.
- Two (2) original prescription containers for each type of prescription (not over-the-counter) medication are required. Each original container must have an allotment of medication that would allow one container of medication to remain in the CCSC Health Center and the second original bottle to travel with the staff member on an off-campus trip.
- Allergy serums must come with specific instructions from prescribing allergist.

Camp Responsibility

- If the nurse or camp director questions the advisability of dispensing a medication at camp, the camp physician/nurse practitioner is to be consulted.
- All medication shall be collected and stored in their original pharmacy labeled container or over-the-counter packaging in the health center under the supervision of a licensed health care professional.**
- All medication shall be taken in the presence of and/or under the supervision of a licensed health care professional. NO MEDICATIONS ARE ALLOWED IN CABINS WITH CAMPER.**
- Nurses, under the supervision of the camp physician/nurse practitioner, are to assume responsibility for administering medication requiring injection.
- All medication records will be kept to document the dispensation of all medications at camp.
- It is the responsibility of the staff member to be responsible for their own medication schedule.
- All medications will be returned to the staff member at the end of their employment or properly disposed of if undeliverable.
- All medications and their administration will be confidential and communicated to appropriate persons on a need-to-know basis.

Authorization for Dispensing of Medications at the Camp Health Center (Completed by Licensed Provider)

NAME _____	Date of Birth _____	
Name of Licensed Provider _____	Title _____	
Medication(s) _____		
Route of Administration _____	Dosage _____	
Frequency _____	Time(s) of Administration _____	
Specific directions or information for administration _____		
Special side effects, contraindications, or possible adverse reactions to be observed: _____		
Date of order _____	Discontinuation Date _____	Diagnosis _____
Any other medical conditions or medications? _____		
Date _____	Signature of Licensed Provider _____	

Prescription Medication Count (Completed by Staff Member)

CCSC requires two original prescription containers for each type of **prescription (not over-the-counter) medication** which will be distributed through the camp health center. Please verify the number of pills in each container being provided to camp using the outline below.

- Medication: _____ Number in Container #1 _____ Number in Container #2 _____
- Medication: _____ Number in Container #1 _____ Number in Container #2 _____