CAMP YACHAD 2010 STAFF HEALTH EVALUATION FORM:

PART I TO BE COMPLETED BY ADULT STAFF MEMBER/PARENT FOR STAFF UNDER 18

Name _____DOB _____Age _____

Address _____

Home Phone _____Social Security Number _____

Cell Phone _____ E-mail _____

Insurance Carrier _____Policy # _____Group # _____

EMERGENCY CONTACTS AND HEALTH CARE PROVIDERS

Emergency Contact Name	Relationship	Home Number	Work Number	Cell Number	Authorized to Make Decisions? YES NO

Health Care Provider	Name	Address	Phone Number	FAX Number
Primary Care Provider				
Dentist				

I hereby give permission to the medical personnel selected by the JCC to secure and administer treatment, including x-rays, routine tests and hospitalization.

Parent/Legal Guardian Signature (REQUIRED FOR STAFF UNDER 18) _____**Date**_____

Staff Signature (For staff over 18)_____ **Date** _____

PART II TO BE COMPLETED BY HEALTH CARE PROVIDER

Medical Information: Date of Physical Examination ____/____/____ Results of physical examination normal? Yes___ No___

Immunization record attached? Yes_____

Inoculations needed for camp employment - I verify that the following are up to date: **Date of Last Tetanus** ____/____/____

DPT Yes____ No____ **Polio** Yes____ No____ **Tuberculin Test done since 9/09** Yes____ No____

Allergies and Reactions (Include any special care plan needed)

Food _____

Medicine _____

Other (include insect sting) _____

General Health:

Height _____ Weight _____ Blood Pressure _____

Has staff member had any serious illness or accidents? No_____ Yes____ (If yes, explain)

_____

Hospitalizations_____Handicaps_____

Is staff member currently taking any medication? No_____ Yes____ (If yes, explain)

_____

Name of Medication	Indication	Dose	Frequency	Time(s) of Day

Is there a history of the following? (If yes, explain)

Chicken Pox_____ Heart Disease_____ Measles_____ Asthma_____ Mumps_____

Seizure Disorder_____ Diabetes_____ German Measles_____ Explanation _____

List medical conditions/ongoing surgical concerns_____

As a health care provider licensed by the State of New Jersey, I have examined the individual listed above and found him/her fit to participate in all activities.

Health Care Provider Signature _____**Date** _____

Please Complete the Reverse Side if Under 18