Fernwood Cove Staff Health Form

Pages 1 and 2 are to be completed by the staff member and returned to camp by May 1, 2008. Page 3 is to be completed by the staff's medical provider and it can be sent to camp separately and is due June 1, 2008.

Return to:
Fernwood Cove
350 Island Pond Road
Harrison, ME 04040
Tel: (207) 583-2381 . Fax: (207) 583-6016

Staff Name:___________________________SS#:_____________ Date of Birth:(M/D/Y)___________Gender (M/F)___

Permanent Address: ____

Emergency Contact 1: ____

Address: ____

Phone # ____ Relationship: ____________________________________

Emergency Contact 2: ____

Address: ____

Phone # ____ Relationship: ____________________________________

Health Information:

Please list all medications taken on a regular basis including over-the-counter or nonprescription drugs. Attach additional pages to the back of this form if more room is needed (please include your name and date of birth). All medication must be kept in the original packaging when brought to camp.

☐ This person takes no medications on a routine basis.

Medication	Dosage	Time	Reason for taking

Over-the-counter medications: Fernwood Cove stocks many over-the-counter (OTC) medications in tablet, chewable and liquid form. Unless specifically indicated, we will administer OTC medication from our stock. If there is any OTC mediations that you should not have, for example, due to allergy or prescription drug interaction, please list those medications below:

____

Please list all allergies/other conditions (including medical, food, environmental and other). Please describe the reaction experienced when exposed to these allergens. Make special note of any anaphylactic reactions-those that require EPI Pen.

____
____
____

Physician: ____ Phone Number: ____
Dentist: ____ Phone Number: ____
Mental Health Provider:_____________________________________ Phone Number:____
Other Physician:____ Phone Number:____

Insurance Information: Please fill out the information below and attach a photocopy of your insurance card to the back of this form.

Policy #:_______________________________________ Insurance Carrier Name: ____
Policy Holder: ___________________________________ Carrier Phone Number: ____
Policy Holder's DOB: ___________________________ Carrier Address: ____

IMPORTANT- This form must be signed in order for you to attend Fernwood Cove.

This Health form is complete and correct as far as I know. The person herein named has permission to engage in all camp activities except as noted by me or the examining medical personnel.

I hereby give permission to medical personnel selected by Fernwood Cove to provide routine health care; to administer prescription and over-the-counter medication; to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; seek emergency treatment if necessary and to provide or arrange necessary related transportation for me. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Fernwood Cove to secure and administer treatment, including hospitalization, injection anesthesia, surgery for the person named above. This form may be photocopied for trips out of camp.

Signature____ Date: _____________

Print name: ____

General Health Questions:

Please circle yes or no if you have ever had or does have:

1. Frequent Headaches or Migraines	Yes/No	10. Lactose Intolerance	Yes/No
2. Heart Defect/Disease	Yes/No	11. Motion Sickness	Yes/No
3. Seizures/Epilepsy	Yes/No	12. Mononucleosis (within last 12 months)	Yes/No
4. Bleeding or Clotting Disorders	Yes/No	13. Wears glasses or contact lenses	Yes/No
5. Joint Problems (Knees, Ankles, back)	Yes/No	14. Orthodontic appliance	Yes/No
6. Asthma (attach action plan)	Yes/No	15. Head lice (recent)	Yes/No
7. Diabetes	Yes/No	16. Sleep Disturbance (bedwetting, Sleep walking)	Yes/No
8. Any Surgery or Operations	Yes/No	17. Abnormal Menstrual History	Yes/No
9. Eating Disorder	Yes/No	18. History of Lyme Disease (any long term effect)	Yes/No

Please explain and provide dates if you answered yes to the statements above.

____

____

____

____

____

Please describe any chronic or recurring illness not mentioned above?

____

Have you had any recent illness, injury, or infectious disease?

____

____

Head Lice: If you come to camp or contracts lice at camp you will be treated with over-the-counter products by our Camp Health staff. Please note that she will be asked to sleep in the Health Center until the infestation is under control. **Please Initial ____**

Restrictions/Limitations:
Explain any restrictions or limitations to activity:

____

List any dietary restrictions:

____

Mental, Social and Emotional Health: The information you provide will be shared with great care among medical staff and camp directors.

This staff member has been diagnosed with Attentions Deficit Disorder (ADD) or (ADHA)? Yes/No
Has this staff member been diagnosed with any other specific mental health concern?
(i.e. depression, OCD, panic/anxiety disorder) Yes/No
Describe: ____
This staff member has seen or is currently seeing a professional to address a diagnosed mental health concern? Yes/No
Please explain:____

____

This staff member has a recent emotional health concern (loss, change in family, etc.) Yes/No
IF yes, please explain briefly: ____

____

Other Information: Please provide any additional information about the participant's health, which may not have been discussed on this form. Attach another sheet if necessary with the participants name and date of birth.

Health Care Recommendations by Licensed Medical Personnel:

Name of Staff:____ Date of Birth:(MM/DD/YYYY) ____________

Dear Medical provider,
You are being asked to recommend this staff member for the participation in a 2 month, sleep-away camp program. Fernwood Cove is an all girl's summer camp located in Waterford, Maine. Our program is very active program including swimming, waterskiing, tennis, gymnastics, ropes and rock climbing, soccer and dance. Our terrain is hilly and we are in the woods close to southern Maine. The bunks are not air-conditioned and the staff are routinely exposed to insects, pollens, trees, molds, heat and humidity. If you require further information before recommending staff to participate in our program please feel free to contact us at: 207-583-2381.

Immunization History:

Please provide dates for immunizations: (Month/Day/Year) or attach a sheet with this information and your name and date of birth.

Vaccine:	Dates	M/D/Y	M/D/Y	M/D/Y	M/D/Y	M/D/Y
DTP						
TD (tetanus/diphtheria)						
Tetanus or booster						
Polio						
MMR						
Or Measles						
Or Mumps						
Or Rubella						
Haemophilus Influenza B						
Hepatitis B						
Varicella (Chicken Pox)						
Meningococcal (MCV4)						
Other						

Which of the following has the participant had?

☐ Measles ☐ Chicken pox ☐ German measles ☐ Mumps

☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

TB Mantoux Test: Date of last test___________ Result: ☐ Positive ☐ Negative

In the last 12 months has the participant had?

☐ Whooping Cough ☐ Mononucleosis

Medical Recommendation:

Please list in detail prescribed medication for use while at camp (name, dosage, time):

____
____
____
____
____

Known allergies (please include type of reaction that occurs):

____
____

Restrictions:
Activity restricitons____
Diet restricaitons____

___________BP ___________ Height __________ Weight

I examined this individual on ________________. (Exam date must be within 24 months of camp attendance)

Based on the information presented to me and upon my examination of the participant, I recommend them in my opinion to be able to participate in an active camp program.

Signature of Licensed Medical Personnel: ____

Printed:____ Date: ___________________________

Address____ Phone #: _________________________

This form must be signed by licensed medical personnel in order to attend Fernwood Cove.

Return to: Fernwood Cove, 350 Island Pond Road Harrison, ME 04040 by June 1, 2008 Tel: (207) 583-2381. Fax: (207) 583-6016