**Health History Form for Seasonal Employees**

\_\_\_

\_\_\_

\_\_\_

**Allergies:** *Our expectation is that, if needed, the employee will have an EpiPen® and know how to use it if anaphylaxis is a concern.*

Food Allergies:

Describe reaction and management of reaction:

Medication Allergies:

Describe reaction and management of reaction:

Other Allergies:

Describe reaction and management of reaction:

**Nutrition:** *Our expectation is that staff set an example for campers by eating the provided meal. We will work with most medically prescribed*

*diets, such as gluten-free and lactose intolerant, but may not be able to cater to all individual food preferences. Discuss concerns with the camp director prior to the start of camp.*

\_

\_

\_

\_

I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.

I am a vegetarian of this type:

* Semi-vegetarian (no pork or beef)
* Pesco (no pork, beef, or chicken)
* Lacto (no meats, fish, seafood, or eggs)
* Ovo (no meats, fish, seafood, or dairy)
* Lacto-ovo (no beef, pork, chicken, seafood, or fish)
* Vegan (no meats, seafood, eggs, or dairy)

\_

\_

I do not eat products because of religious beliefs.

Health History Form for Seasonal Employees

Name:

First Middle Last

Permanent

Address:

Street Address

City State/Country Zip/Code

Phone Number: If you have questions about our camp health

services, please call or email Lisa Elder at lrelder@indiana.edu or 765-349-5135 x 5212

* **Please complete a camp physical and have the last page signed by a physician, LPN, or nurse.**
* *Return this form to camp office at least four weeks prior to your arrival.*
* *Notify the camp director if you are exposed to a communicable disease within three weeks of beginning your job.*
* *The camp expects that you arrive in good health and capable of performing the essential functions of your position. If you have concerns regarding this, speak with the camp director prior to arrival.*
* *Information on this form is available to Health Center staff and your work supervisor(s) as necessary.*

\_\_\_

\_\_\_

\_\_\_

\_\_\_

































































**Immunization History:**

Date (month/year) of TB test (please provide documentation):

Date (month/year) of your most recent tetanus immunization:

Have you completed the immunizations that were required for school attendance?  Yes

* No

**Chronic Concerns:** *Check all that pertain to you and provide information about supportive healthcare. Your supervisor expects that staff*

*who have chronic health concerns are capable of performing the essential functions of the job for which they have been hired. If you have any concerns, please contact your supervisor.*

\_ \_ I have no chronic health concerns.

\_

\_ I have the following chronic health concern(s):

* Asthma
* Diabetes
* Fainting
* Back pain or injury
* Headaches, Migraines
* Difficulty breathing
* Surgical history
* Knee or ankle weakness
* Sleep problems
* Dysmenorrhea
* Seizure disorder:
* Other:

**Medication:** *While sleeping in camper cabins, medications must be locked securely in the Health Center.*

\_ \_ I do not take any medications.

\_

\_ I take medications that the use (or non-use) could impair the ability to perform the essential functions of this job.

Please List:

**General History:** *If you answer “Yes” to any of these questions, provide more information at the end of this section.*

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

13.

Have you ever been hospitalized? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever passed out during or after exercise? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever been dizzy during or after exercise? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever had chest pain during or after exercise? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Do you tire more quickly than your friends during exercise? . . . . . . . . . . . . . . . . . . . . . . . . . . Have you ever had high blood pressure? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . Have you ever had a racing heartbeat or skipped heartbeats? . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever been knocked out or become unconscious? . . . . . . . . . . . . . . . . . . . . . . . . . . . . Have you ever had a seizure? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever had a stinger, burner, or pinched nerve? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever had heat or muscle cramps? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever been dizzy or passed out in the heat? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever sprained, strained, dislocated, fractured, broken or had repeated

swelling, or other injuries to any of your body areas? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Yes

Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes

No

No No No No No No No No No No No

Yes

No

If so, where?

* Head
* Arm, hand
* Shoulder
* Ankle
* Leg
* Back
* Neck
* Hip
* Chest
* Foot

14.

Have you been in countries other than the United States in the past nine months? . . . . . . . .

If yes, list the countries and the time spent in them.

Yes

No

Country:

Dates:

Country:

Dates:

Country:

Dates:

15.

16.

Have you ever had an eating disorder? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

Have you ever had emotional difficulties for which professional help was sought? . . . . . . . .

Yes

Yes

No

No

Use the space below to explain and/or provide more detail about the General Health questions to which you responded “Yes.”

#

#

#

#

**Physician**

Name of your physician: Office Phone ( )

Name of your dentist/orthodontist: Office Phone ( )

**Paying for Health Care**





You are financially responsible for healthcare provided by all other providers.

If you will be using personal insurance while working at camp, know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

**Emergency Contact:** *Who do you want us to contact in an emergency?*

First

Preferred

Relationship

to You:

Contact: Phone: ( )

Alternate

Preferred

Relationship

to You:

Contact: Phone: ( )

**Authorization for Healthcare:** *Parental signature required for staff under 18 years of age.*

This health history is correct. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp’s Health Center staff in providing care to me and may be reviewed by my work supervisor(s).

*Signature of*

*Staff Person:*

*Date:*

*Signature of*

*Parent (if needed):*

*Date :*

**Staff Member STOP Here.**

**Documentation by Physician, LPN, or nurse**

**Physician or Medical Staff:** This person is an employee at Bradford Woods. The job requires rigorous physical, mental, and emotional

stamina and requires the individual to be outside in a variety of weather conditions. If you question the person’s suitability for the position, please talk with him/her about your concerns and develop a plan to address that concern. You may also speak with one of our Camp Professionals by calling 765-342-2915 and asking for someone in the Recreation Therapy Department.

Please address the items below and list any additional notes in the space provided:

A.

B.

C.

D.

E.

Any signs/symptoms of illness or injury upon arrival? . . . . . . . . . . . . . . . . .. . . . . . . .

Any history of exposure to communicable diseases? . . . . . . . . . . . . . . . . . . . . . . . . . . Any additions, corrections, or clarifications to information on this form? . . . . . . . . . As necessary, medication has been reviewed with the healthcare provider. . . . . . . . Any signs/symptoms of head lice? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .

NO

NO NO NO NO

YES as noted below

YES as noted below YES as noted below YES as noted below YES as noted below

*Check one of the following:*

* Employee has no reported physical or emotional concerns that will impact his/her ability to perform the job.
* There are symptoms, concerns, or limitations that may impact the employee’s ability to perform the job. Please list below:

AUTHORIZATION:

By signing this form, you are telling us that, in your opinion, this person is both physically and emotionally ready to participate as an employee at our camp, except as noted in the comments above.

Signature: Date: