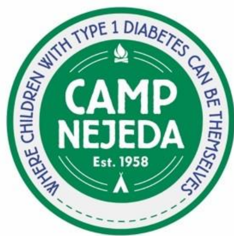

STAFF HEALTH HISTORY 2024

For All Staff (with or without Diabetes)

Name____Birthdate____________Gender_____Age _______
(Last) (First) (MI)

Gender Identity ☐ Male ☐ Female ☐ Non-Binary/Non-Conforming ☐ Other ___________________

Race (select all that apply) ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic
☐ Native Hawaiian/Pacific Islander ☐ American Indian/Native American ☐ I choose not to disclose

To celebrate the diverse backgrounds of our staff at Camp Nejeda, flags are displayed in the dining hall which represent our cultural heritage. If you would like to participate, please tell us which countries you would like included: ____

Home Address ____

Email Address ____

Parent or Guardian____ Phone(s) ___________________

If not available in an emergency, notify: Name____

Relationship________________________Phone(s)____

HEALTH HISTORY

☐ Diabetes
☐ Kidney Disorder
☐ Frequent Ear Infections
☐ Hypertension
☐ Heart Defect/Disease

☐ Asthma
☐ Bleeding/Clotting Disorder
☐ Hepatitis
☐ Other: ___________________
____

☐ Convulsions/Seizures
Most recent date: _________
☐ Psychiatric Treatment
Details: _________________
____

Date of last tetanus shot_________________(Very Important)

Operations or serious injuries (include date) ____

Disability, chronic or recurring illness or medical condition (other than diabetes) ___________________________
____

Do you take any medication other than insulin? __________
If yes, list the name of medicine, times and doses (be specific):

NOTE: For staff under age 18, a Medication Administration Form is required for each medication.

Medication	Dose	Time
____________________	____________________	____________________
____________________	____________________	____________________
____________________	____________________	____________________

CONTINUED ON BACK

ALLERGIES

- ☐ Insect Stings
- ☐ Environmental Allergies
- ☐ Penicillin
- ☐ Latex Allergy
- ☐ Drug Allergy: ____________________ ____________________________
- ☐ Other (foods, plants): _____________ _____________________________

Name of Primary Care Physician: ____ Phone: ______________________

Name of Endocrinologist: ____ Phone: ______________________

Please notify the camp if you have had any illness in the three weeks prior to camp.

YOU MUST BRING YOUR INSURANCE CARD TO CAMP AT INTAKE TO BE PHOTOCOPIED.

Name of Subscriber _________________________________ Subscriber's Date of Birth ___________________

Subscriber's Employer _______________________________ Subscriber's Occupation ____________________

Please Note: YOU ARE NOT ALLOWED IN CAMP WITHOUT A COPY OF YOUR IMMUNIZATION RECORD FROM YOUR DOCTOR OR SCHOOL. If records are already on file, only updates are required (including tetanus).

Staff signature____ **Date** ______________________________

(A parent/guardian signature is ALSO required (below) for any staff member who will not yet be 18 on the day that staff orientation starts.)

Parent/Guardian consent for staff members who are minors

I give consent to the administration of insulin and whatever other medical care may be deemed necessary while at camp. I understand that as a staff member, my child's insulin administration is NOT being supervised by Camp Nejeda. In case of MEDICAL EMERGENCY, I understand every effort will be made to contact the staff person's parent(s) or guardian(s). I do hereby state that I am the parent/guardian having legal custody of: ______________________________________ a minor, age_________.

I authorize Camp Nejeda to consent to any laboratory or X-ray examination, anesthetic, medical, or surgical treatment and hospital care to be rendered to my child under the supervision of a licensed physician. I hereby release the camp from any liability for any accident or injury to said person occurring at camp or on a camp-sponsored trip off the site. Forms may be photocopied as necessary.

Signature _______________________________________ **Date** _____________________

Printed Name ___________________________________ **Relationship to Camper** ____________________