SO4S (Students Opting 4 Success) Day Camp
Staff Health History Form

Page One: To Be Completed by Staff Member

Camp Location: _____

Your Name *(Last/First/M.I.)*: _____|_____|____

Birthdate: _____/_____/_____ Sex *(circle one)*: Male Female

Permanent Address: _____ Phone#: _____

Emergency Contact #1 *(Name/Phone #)*: _____|_____

Emergency Contact #2 *(Name/Phone #)*: _____|_____

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1) Please list any known allergies you have/have had in the past (medications, food, etc.):
_____
_____
_____

2) Do you require any medication that might impair your ability to carry out the essential functions of your job during the summer (please choose one)?

YES NO

****If yes, you MUST discuss details of your medication with the Camp Health Director.*

3) Do you have any pre-existing medical conditions that might impair your ability to carry out the essential functions of your job during the summer (please choose one)?

YES NO

****If yes, you MUST discuss details of your medication with the Camp Health Director.*

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby authorize Students Opting 4 Success to obtain necessary emergency medical treatment on my behalf. If deemed appropriate, Students Opting 4 Success will also contact any listed emergency contact(s) in a timely manner.

Print Name: _____ Signature: _____ Date: _____

Page Two: MUST Be Completed (Signed & Stamped) By A Physician

HEALTH HISTORY

Full Name: _____ Birthdate: _____ Sex: M F

Check box if individual has ever had any of the listed afflictions, provide appropriate dates:

- ☐ Rheumatic Fever _____
- ☐ Seizures _____
- ☐ Diabetes _____
- ☐ Asthma _____
- ☐ Chicken Pox _____
- ☐ Other Past Illnesses (please list)
  - _____
  - _____
  - _____

Operations and/or Serious Injuries (dates): _____
Hospitalization (dates): _____
Chronic and/or Recurring Illness(es): _____
Appliance(s) Worn (glasses, contacts, etc.): _____
Prescription Medication Taken: _____

IMMUNIZATION HISTORY

A copy of the individual's immunization records may be attached in lieu of completing this section. This must include the dates (month/year) of all basic immunizations and most recent boosters.

DTaP/DTP/Tdap/DT/Td	Date: _____	Date: _____	Date: _____
Polio	Date: _____	Date: _____	Date: _____
MMR	Date: _____	Date: _____	Date: _____
Hib	Date: _____	Date: _____	Date: _____
Hepatitis B	Date: _____	Date: _____	Date: _____
Varicella	Date: _____	Date: _____	Date: _____
PCV	Date: _____	Date: _____	Date: _____
Other: _____	Date: _____	Date: _____	Date: _____

PHYSICAL EXAM RESULTS

On the basis of my findings and with my knowledge of the above-named individual, I conclude that:

1) He/She is currently NOT exhibiting any signs or symptoms of a communicable disease that could be transmitted while working with children. YES | NO

2) He/She is currently NOT exhibiting any signs or symptoms suggestive of an emotional or psychological disorder that would hinder their ability to care for children. YES | NO

3) Is there any work-related activity from which the individual should be exempt or a limited participant in, due to health reasons? YES | NO

Exam Date: _____/_____/_____ Physician's Name (print): _____

Please Stamp:

Examining Physician (signature):

_____