Staff Last Name _____ First Name _____

World Affairs Seminar/housed at Carroll University – 6/23/18 – 6/29/18
RECORD OF MEDICAL HISTORY

Because we want to support your ability to do your job well, please complete this form accurately and completely.

PLEASE TYPE OR USE INK AND PRINT CLEARLY

Name: _____
Last First Middle

Gender: _____ Date of birth: _____ Place of Birth:_____

Permanent Home Address: _____

_____ Preferred Telephone: _____
City State Zip Code

Country of Residence: _____ E-mail: _____

Your Contract Start Date: _____ End Date: _____

- *Return this form to our office as soon as possible – at LEAST one week before you arrive. People hired within one of their start date should not send this form: bring it with you and give it to the nursing staff at camp.*
- *Keep a copy of the completed form for your records; note changes that occur and inform the nurse of these changes.*
- *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 to doing the job for which you were hired.*
- *Information on this form is available to Health Center staff and your work supervisor(s).*

Allergies: Check those that apply to you.

___ I have no known allergies.

___ I have an allergy to this food: _____ This causes anaphylaxis? ___ Yes ___ No
Describe what happens if you eat this food and how the reaction is managed:
_____

___ I am allergic to this medication/s: _____ This causes anaphylaxis? ___ Yes ___ No

___ I am allergic to these substances: _____ This causes anaphylaxis? ___ Yes ___ No
Describe what happens if you eat this food and how the reaction is managed:
_____

Date of last Tetanus vaccination _____

Past Surgery/Hospitalizations:_____

Staff Last Name _____ First Name _____

Nutrition: Please list any dietary needs Health Concerns: Check the conditions that you have

____ Asthma	____ Hearing/ Vison Loss
____ Convulsions / seizures	____ Heart Problems
____ Diabetes	____ High Blood Pressure
____ Other:	

MEDICATION HISTORY: *Bring enough medication to last or bring your written prescription to order a refill. Prescription meds MUST be in pharmacy containers with appropriate labels; other remedies must be in original container.*

_____ I do not take medication on a routine basis.

_____ I take routine medication (include vitamins) as noted below.

Name of Medication	Reason for Taking It	Dose Given & When	Date Started?
		_ Breakfast Dose _____ _ Evening Meal Dose ____ _ Bedtime Dose _____ _ Other	
		_ Breakfast Dose _____ _ Evening Meal Dose ____ _ Bedtime Dose _____ _ Other	
		_ Breakfast Dose _____ _ Evening Meal Dose ____ _ Bedtime Dose _____ _ Other	

The following medications will be provided to you as needed by the Heath Service staff.

Medication	Dose	Indication
Triple Antibiotic Ointment		Abrasions, superficial wounds
Wound wash	as needed	Wounds
Hydrocortisone cream	1%	Puritis / rash
Calamine Lotion		Puritis / rash
Aloe vera gel		Sunburn
Acetaminophen	dose per age/weight per label	Pain or fever
Ibuprofen	dose per age/weight per label	Pain or fever
Miralax	dose per age/weight per label	Constipation
Kaopectate	dose per age/weight per label	Diarrhea
Tums	dose per age/weight per label	Indigestion
diphenhydramine	dose per age/weight per label	Itching / reaction
Pseudoephedrine	dose per age/weight per label	Nasal congestion
Miconazole Powder		Pruritus/suspected fungal infection

Name of your physician: _____ Office Phone (____) _____

Staff Last Name _____ First Name _____

Mental & Emotional Health Information

Do you have any mental or emotional health conditions that may impact your work (e.g. ADHD, OCD, depression, anxiety, bipolar, eating disorders)? ___ Yes ___ No

If "yes" attach a statement that:

(a) Describes the concern and your management plan for addressing it while working at camp, and

(b) Describes the support needed

Paying for Health Care:

- There is no charge for health care provided by the camp's nurses.
- Staff are financially responsible for health care provided by out-of-camp providers.
- Bring your insurance card and know how to use it.

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

First Contact: _____ Phone: (_____) _____

Relationship to You: _____

Alternate Contact: _____ Phone: (_____) _____

Relationship to You: _____

Authorization for Health Care: Parental signature required for staff less than 18 years of age

This health history is correct insofar as I know. 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 Health Care staff in providing care to me and may be reviewed by work supervisor.

Signature of Staff Person:_____ **Date:**_____

Signature of Parent (if needed):_____ **Date:**_____