Church of the Brethren Western Plains District

Camp Health Form for Staff

This form must be completed within 12 months of camp and submitted to the Camp Director 2 weeks prior to camp session. Failure to bring this record to camp will require that the staff member be checked by the camp's physician at the staff member's expense. (Please print.)

Part I – For staff person to complete

Your Name: _____ Birth Date:_____

Date of last visit to physician within 12 months of camp session: _____

Health Insurance Provider: _____ Policy #: _____

Health Ins. Address: _____ Health Ins. Phone: _____

City:_____ State:_____ Zip Code_____

Your own health insurance will provide primary coverage should you become sick or injured. The camp carries a very modest amount of insurance (secondary) for uninsured staff, and you will be responsible for any costs that exceed the camp's coverage.

Your Doctor: _____ Doctor Phone: _____

Doctor's address:_____ _____

Your Dentist: _____ Dentist Phone: _____

Dentist's address:_____ _____

Your health conditions and prescribed medications with directions: _____ _____

_____

_____ _____

_____ _____

(Prescription medication brought to camp must be in original bottle with directions and given to the nurse for safe keeping. If you have asthma, be sure to bring your inhaler. Also bring your epi-pen if you have one.)

Dietary needs: ____dairy-free ____gluten-free ____low-sodium ____vegetarian ____vegan

Food allergies:_____ _____

Your Emergency Contact Person: _____ Phone: _____

Authorization for Emergency Medical Care – Health Insurance Information

I hereby give my permission to camp officials to call a doctor or emergency medical service, and for the doctor, hospital, or medical service to provide emergency medical or surgical care for me, should an emergency arise. It is understood that camp officials will make a conscientious effort to locate the emergency contact listed here, if necessary, before any action is undertaken. If it is not possible to locate the emergency contact listed, I accept the expense of emergency medical or surgical treatment (to the extent that it is not covered by my health care insurance, or the limited, camp-provided insurance).

Signature: _____ **Date** _____

Part II – For physician or nurse practitioner to complete *(On back of this form)*

Part II – For physician or nurse practitioner to complete

Note: This person is planning to attend a weeklong, resident camp away from his/her home and some distance from care. The camp will have a health supervisor who has at least completed an advanced first aid course. Your response to all these questions will help care for this person. Additional information may be added below.

Patient's name:_____ Birth date:_____

Recent history of serious lacerations, injuries, illnesses, or surgery:_____

_____ _____

_____

_____

_____

Date of most recent Tetanus shot:_____

Penicillin or other drug allergies/reactions: _____

Current medications, including directions: _____

Other allergies:_____

Special dietary requirements:_____

I have examined this patient and found him/her to be in satisfactory physical condition and capable of active participation in a regular camping program EXCEPT as follows:

_____

_____

Signature of physician/nurse practitioner:_____ Date:_____

Printed name of physician/nurse practitioner: _____

Address:_____ Phone: _____

Please attach a copy of your health insurance provider card/certificate (front & back.)