Oasis Day Camps 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.):

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____

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 Oasis Children's Services to obtain necessary emergency medical treatment on my behalf. If deemed appropriate, Oasis Children's Services 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):

____

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Page Three: To Be Completed by Staff Member <u>if under the age of 18</u>

Camp Location: ____

Your Name: ____

Birthdate: _____/_____/________ Age: ____________________

Home Address: ____

Home Phone: ______________________ Personal Phone: ______________________

Parent/Guardian/Custodian Contact #1:

Name: ____

Home Address: ____

Personal Phone: ______________________ *Work Phone:* ____________________

Parent/Guardian/Custodian Contact #2:

Name: ____

Home Address: ____

Personal Phone: ______________________ *Work Phone:* ____________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I hereby authorize Oasis Children's Services to obtain necessary emergency medical treatment on my child's behalf. If deemed appropriate, Oasis Children's Services will also contact any listed emergency contact(s) in a timely manner.

My relationship to staff member: ____

Print Name: ________________________ Signature: ____________________ Date: ________