2012 STAFF HEALTH AND MEDICAL RECORD

Gesher Summer Camp

110 South Orange Avenue, Livingston, NJ 07039 (973)597-3699

SECTION I: GENERAL INFO

Staff Name ____

Birth Date ____________________ Age ________ Sex ☐ M ☐ F Phone # ____________________

Home Address ____________________________ City/State/Zip ____________________________

SECTION II: GENERAL MEDICAL/INSURANCE INFO

Primary Physician/Pediatrician's Name _________________________ Phone # __________________

Address ________________________________ City/State/Zip ____________________________

Medical Insurance Co ____________________________ Policy # ___________________________

SECTION III: EMERGENCY CALL INFO *(Parent/guardian contact information required for all staff under 18.)*

Mother/Guardian _________________ Work Phone # ______________ Cell Phone ______________

Father/Guardian _________________ Work Phone # ______________ Cell Phone ______________

Emergency names and phone numbers: ***(this part must be filled out or the form will be returned!!!)***

1. Name ____ Relation ______________________

   Home Phone ________________ Work Phone ________________ Cell Phone ________________

2. Name ____ Relation ______________________

   Home Phone ________________ Work Phone ________________ Cell Phone ________________

3. Name ____ Relation ______________________

   Home Phone ________________ Work Phone ________________ Cell Phone ________________

SECTION IV: EMERGENCY MEDICAL INFO *(To be completed by parent/guardian if staff member is under 18.)*

Allergies: (Medicine, food, insect toxin, other) ____

Inhaler/Nebulizer ☐ Yes ☐ No Inhaler sent to camp ☐ Yes * ☐ No Epipen ☐ Yes* ☐ No

Medication used for allergies _______________________ Allergy medication sent to camp ☐ Yes* ☐ No

History of: ☐ Asthma ☐ Convulsions ☐ Diabetes ☐ High Fevers

Explain ____

Any condition requiring daily medication (at home or camp)____________________________________

Medication and dosage for above ____________________________ Meds sent to camp ☐ Yes* ☐ No

Time of Administration ___________

Should medications be sent on trips: ☐ Yes* ☐ No

Any physical limitations ____

Does camper wear: ☐ Glasses ☐ Contact lenses ☐ Braces ☐ Hearing Aide

***** *If* ***any*** ***medication is coming into camp, it must be accompanied by Physician Authorization Form. The form should state the staff member's name, the drug name, amount to be given, and time to be given. Prescriptions and "over the counter" medications MUST BE IN ORIGINAL LABELED BOTTLES OR CONTAINERS. For prescription drugs, pharmacies will provide a duplicate empty bottle which is labeled and can be sent to camp. These rules apply to overnight and late stay medications, as well as daily medications.***

SECTION V: MEDICAL TREATMENT AUTHORIZATION

I hereby give permission to the Gesher Summer Camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including the ordering of x-rays, administering of anesthesia, or routine tests, as necessary. I agree to the release of any records necessary for insurance purposes. I give permission to Gesher to arrange necessary related transportation for me/my child.

I understand that attempts will be made to contact emergency numbers listed on this form, as necessary, before initiating this authorization. In the event I require emergency care, I hereby give permission to the physician selected by Gesher to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out off the premises. **(Parent/Guardian signature required for all staff members under 18 years of age.)**

Date _______________________ Signature ____________________________________

Staff Name ___________________________________ **DOB** _____________ **Ht.** __________ **Wt.** _________

Medical History *(to be completed and signed by physician)*

*JKHA vaccination and health records are not accessible during the summer. Please submit requested information.

Immunizations (please mark dates received, including multiple vaccinations)

MMR #1 ______________ MMR #2 ______________

DPT/DaPt (Circle Type) #1_________ #2 _________ #3 _________ Booster #1_________ #2 _________

OPV/IPV (Circle Type) #1_________ #2 _________ #3 _________ Booster #1_________ #2 _________

HIB #1______________ #2 ______________ #3 ______________ #4 ______________

Hep B #1______________ #2 ______________ #3 ______________ Hep A #1______________ #2 ______________

Varivax #1______________ #2 ______________

Prevnar #1______________ #2 ______________ #3______________ #4 ______________

Menactra ______________

Gardacil #1______________ #2 ______________ #3 ______________

Tuberculin Test: PPD Intradermal Date ________________ Result ____________mm

Chicken Pox (year of infection/varivax vaccination-please specify which) ______________________________

Current or Past History

	NO	YES	YEAR	DETAILS
Anemia	☐	☐	_____	____________
Arthritis	☐	☐	_____	____________
Asthma	☐	☐	_____	____________
Back Problems	☐	☐	_____	____________
Bed Wetting	☐	☐	_____	____________
Bleeding Disorder	☐	☐	_____	____________
Bronchitis	☐	☐	_____	____________
Chemical Dependency	☐	☐	_____	____________
Chest Pain (from exercise)	☐	☐	_____	____________
Chronic/recurring illness or condition	☐	☐	_____	____________
Convulsions/Seizures Neurological Disorders	☐	☐	_____	____________
Diabetes	☐	☐	_____	____________
Ear Infections (Frequent)	☐	☐	_____	____________
Epilepsy	☐	☐	_____	____________
Eye Ailments	☐	☐	_____	____________
Fainting	☐	☐	_____	____________
Frequent Colds	☐	☐	_____	____________
German Measles	☐	☐	_____	____________
GI/Stomach Problems	☐	☐	_____	____________
Headaches (Frequent)	☐	☐	_____	____________
Heart Ailments	☐	☐	_____	____________
High Blood Pressure	☐	☐	_____	____________
Hospitalization	☐	☐	_____	____________
Kidney Ailments	☐	☐	_____	____________
Measles	☐	☐	_____	____________

	NO	YES	YEAR	DETAILS
Menstrual Problems	☐	☐	_____	____________
Mononucleosis	☐	☐	_____	____________
Motion Sickness/Vertigo	☐	☐	_____	____________
Mumps	☐	☐	_____	____________
Orthopedic Fractures	☐	☐	_____	____________
Pneumonia	☐	☐	_____	____________
Poliomyelitis	☐	☐	_____	____________
Psychological Problems	☐	☐	_____	____________
Rheumatic Fever	☐	☐	_____	____________
Scarlet Fever	☐	☐	_____	____________
Sinusitis	☐	☐	_____	____________
Sleep Walking	☐	☐	_____	____________
Surgery	☐	☐	_____	____________
Thyroid Condition	☐	☐	_____	____________
Tuberculosis	☐	☐	_____	____________
Tumors	☐	☐	_____	____________
Eating Disorders	☐	☐	_____	____________
Anorexia/Bulimia, etc.	☐	☐	_____	____________
Visual:				
Eye Glasses	☐	☐	_____	____________
Contact Lenses	☐	☐	_____	____________
Allergies:				
Hay Fever	☐	☐	_____	____________
Insect Stings	☐	☐	_____	____________
Peanuts	☐	☐	_____	____________
Penicillin	☐	☐	_____	____________
Other: ____				
Lactose Intolerant	☐	☐	_____	____________

Medical Conditions requiring medication daily or at camp: ____

Please list medications/dosage/time of administration:____

Dietary Restrictions:____

Date of Last Physical Exam (within last 365 days): ______________ Can Participate in all Sports? ☐ Yes ☐ No

PRINT Physician Name: ____

Physician Address: ____

Physician Phone # :________________________________

Physician's Signature: ____ Physician Stamp: ________________________

Please return this form to the
Gesher Summer Camp 110 South Orange Avenue Livingston, NJ 07039