

Pilgrim Pines / Camp Squanto Staff Health History and Examination Form



Mail this completed form to:
PILGRIM PINES CONFERENCE CENTER
 220 West Shore Road
 Swanzey, NH 03446
 PRIOR to arriving at camp.

Name _____ Birthdate _____ Sex _____ Age _____
 Parent or Guardian _____ Staff Member SS# _____
 Home Address _____ Phone H _____ W _____
 City _____ State _____ Zip _____
 Second Parent or Guardian _____ Phone H _____ W _____
 If not available in an emergency, notify: _____ Phone _____
 Address _____

Do you carry family medical / hospital insurance?
 Yes No
 If so, indicate: Carrier _____
 Policy or Group # _____

Operations or serious injuries dates: _____

 Chronic or recurring illness: _____

 Dietary restrictions: _____

 Current medication *send with instructions*: _____

 Other diseases: _____

 Name of dentist _____ Phone _____
 Orthodontist: _____
 Family physician: _____ Phone _____

Suggestions on health related information for camp personnel

Health History
Check. Give approximate dates.
 _____ Frequent Ear Infections
 _____ Heart Defect / Disease
 _____ Convulsions
 _____ Diabetes
 _____ Bleeding / Clotting Disorders
 _____ Hypertension
 _____ Mononucleosis
Diseases
 _____ Chicken Pox
 _____ Measles
 _____ German Measles
 _____ Mumps
Allergies *dates not needed*
 _____ Hay Fever
 _____ Ivy Poisoning, etc.
 _____ Insect Stings
 _____ Penicillin
 _____ Other Drugs
 _____ Asthma
 _____ Other *Specify*

Position Held _____

Emergency Authorization for Treatment for staff under 18

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me / or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. The completed forms may be photocopied for trips out of camp.

Signature of parent or guardian or adult camper / staff member _____

Immunization History

Required immunizations must be determined locally. Please record the dates *month and year* of basic immunizations and most recent doses:

VACCINES	Year of Basic Immunization	Year of Last Booster
Diphtheria Pertussis } <i>Whooping Cough</i> } DPT * Tetanus	1. 2. 3.	1. 2.
or		
Tetanus } TD* Diphtheria		
or		
Tetanus		
Oral Polio <i>Sabin</i> * TOPV		
Injectable Polio <i>Salk</i>		
Measles hard measles, red measles, Rubeola		
Mumps		
Rubella German measles, 3-day measles		
Other		
PPD must be done for all staff before arrival	Date tested	Results
Haemophilus influenza b <i>HIB</i>		

Health Examination by Licensed Physician:

The staff member is under the care of a physician for the following conditions _____

Current treatment *include current medications* _____

Explanation of any reported loss of consciousness, convulsion, or concussion _____

Does staff member have epilepsy? Yes No Does staff member have diabetes? Yes No

Recommendations and restrictions while serving on staff _____

Any treatment to be administered at camp *specific doses* _____

Any medically prescribed meal plan or dietary restrictions _____

Any allergies *food, drugs, plants, insects, etc.* _____

Activities to be encouraged or limited _____

I have examined the above staff member within the past year. Date Examined _____

In my opinion, the above's condition does not preclude his/her participation in an active camp program.

Height _____ Weight _____ Blood Pressure _____ Pulse _____

ENT _____ Skin _____ Heart _____ Lungs _____ Throat _____

General Appraisal _____

Licensed Physician's Signature _____

Address _____ Phone _____

Date of Form Completion _____ By _____

Initial if completed by nurse or physician's assistant