

STAFF HEALTH EVALUATION FORM

Hope Valley Ministry, Inc.

Please bring this completed form and immunization records to camp with you.

Form MUST have both Physician's and Parent's Signature (if under 18)

Name: _____ Birthday: _____ Age: _____
Parent/Guardian: _____ Home phone: _____
Address: _____ Cell: _____
Street and Number City/Town State Zip

If not available, in an emergency please notify:

Name: _____ Home phone: _____
Address: _____ Cell: _____
Street and number City/Town State Zip

MENTAL AND EMOTIONAL HEALTH INFORMATION: (circle yes or no)

1. Do you have an emotional health concern that will impact your work?.....yes no
2. Have you been diagnosed with depression, OCD, or an anxiety disorder that will impact your work?....yes no
3. Do you have an eating disorder that will impact your work?yes no
4. Do you have a learning challenge that will impact your work?.....yes no

If 'yes' was the answer to any of the four statements above, attach a statement that:

- A. Describes the concern and your management plan (including any medications) while working at camp:
- B. Describes the support needed from your work supervisor to complement your plan.

CONSENT TO TREAT: This statement **MUST** be signed in order to work at camp.

The health history is correct so far as I know, and I am able to engage in all prescribed camp activities, except as noted by the medical provider and myself. I acknowledge the residential camp experience may expose me to communicable diseases (meningitis, lice, etc.)

Signature: _____ Date: _____

Insurance Carrier: _____

Plan number/Group number: _____ ID Number: _____

For Minors (under age 18): In the event that I, the parent, cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment, and to order injection, anesthesia, or surgery for my child as named above.

Parent signature: _____ Date: _____

IMMUNIZATION RECORDS: Please attach an up to date copy of physician's immunization record and date of last tetanus shot. A complete record shall include immunization dates against diphtheria, haemophilus influenza type b, hepatitis b, measles, mumps, poliomyelitis, rubella, chicken pox, tetanus and meningitis.

Not Immunized (check here)

PHYSICAL HEALTH HISTORY: To be filled *within 1 month prior to arrival at camp.* Please state any allergies to food, medications, etc. any health issues (strep throat, asthma, braces, etc.), and recent injuries (broken bones, sprains, bruises). _____

MEDICAL HISTORY: to be completed by a licensed Health Care Provider

Please give a statement of your evaluation of this applicant's health and fitness to participate in the strenuous activities of camp. If the health history indicates any problems, include any recommendations and restrictions.

Date of last Physical exam _____ **Must be within 24 months** of employment at Hope Valley

Signature of Physician: _____ Date: _____

Address: _____ Phone: _____

MEDICATION INFORMATION: Any and all medications must be included on this side of the health form. Hope Valley Camp has a zero tolerance policy regarding medications - - all medications including prescriptions, over the counter meds, herbal remedies, and dietary supplements must not be kept in living areas occupied by campers. Self-carry emergency medications (inhalers, epi-pen) require prescription and prior approval from the camp nurse. _

Hope Valley Ministry provides the following generic **over the counter medications; campers and staff do not need to supply them.** Please indicate which medications may be administered to you at camp. Only medications marked "YES" and determined to be necessary will be administered at the discretion of the camp nurse. Medications will be dispensed "per label directions" unless otherwise specified.

Medication Name (or store brand/generic)	YES	NO	Comments (specific instructions for dosage)
Tylenol (for fever or pain)			
Advil (for fever or pain)			
Throat Lozenges (for throat irritation)			
Benedryl (for allergic reactions)			
Sudafed (for stuffy nose)			
Calamine Lotion (for insect bites)			
Pepto Bismol (for upset stomach)			
First Aid Cream (for minor cut or scratch)			

Below you must list all medications that will be brought to camp with you. This list **MUST** include all prescriptions, over the counter medications, herbal remedies, and dietary supplements!

Name of Medication/Dosage

Reason for Taking

- ALL MEDICATIONS THAT WILL BE BROUGHT TO CAMP (including prescriptions, over the counters, herbals and dietary supplements) MUST BE LISTED ABOVE!
- IF MEDICATION MUST BE TAKEN ON A TIME SCHEDULE, PLEASE INCLUDE SPECIFIC INSTRUCTIONS WITH TIMES INCLUDED.
- ALL MEDICATIONS MUST BE LABELED WITH YOUR NAME AND DIRECTIONS FOR USE.
- ALL MEDICATIONS MUST BE KEPT WITH THE NURSE AT THE HEALTH CENTER (no meds may be kept in living areas occupied by campers)
- PRESCRIPTION DRUGS MUST HAVE PHARMACIST'S LABEL WITH THE DOCTOR'S INSTRUCTIONS.

Office use only: Arrival screening conducted by _____ (Initials) time/ date _____
 Any updates to health history form?.....Noyes
 Any signs symptoms of illness or injury?.....Noyes
 Any medications given to health center?Noyes
 Any special needs of this person while at camp?Noyes
 Any yes' note here _____

Left camp with the following concern _____

 Parent/guardian was notified

Signature of RN on duty _____ Date _____

Signature of staff member _____ Date _____