Camp Judah STAFF Health Form

Camp Hickory Hill
2970 Kohler Rd.
Varysburg, NY 14167
(585)535-7832

This form MUST be accurately completed by all camp staff members 19 years and older and submitted with an application form. (Staff members under age 19 must submit the two-part Camp Judah Camper Health Form.) Please be certain you are good health and up to the physical demands upon arrival at camp. We will be unable to safely accommodate some types of medical conditions. Please contact the camp director if you have questions regarding this.

PART ONE

Please be advised that we are subject to New York State laws and require the EXACT information requested. Failure to document this information will result in delay of registration of your camper.

Name_____ **Gender**_____**Date of Birth**_____
Address_____**City**_____**State**_____**Zip**_____

PERSON TO CONTACT IN CASE OF EMERGENCY:
1. Name_____Relationship to camper_____Phone _____
2. Name_____Relationship to camper_____Phone _____

Health Insurance Information:
Carrier_____Type_____
Policy # _____ Phone # ( )_____
In Whose Name? _____

IMMUNIZATIONS - We must have dates (month/year). It is not sufficient to write "Up-to-date." It is sufficient to attach a copy of immunizations provided by your medical care provider. Please include COVID Vaccine types and dates if applicable. If no immunizations have been given, we must have documentation attached.
DPT Series _____ _____ _____ _____ _____ Tetanus _____ Polio OPV (Sabin) _____ _____ _____ _____
German Measles _____ _____ Measles Vaccine (live)_____ _____ Mumps _____ _____ Hepatitis B _____ _____
TB Test (latest) _____ Results _____ Hib _____ _____ _____ _____ Varicella Chicken Pox _____ ____
*COVID Vaccine type: _____ Dates: _____ _____ (attach copy of proof)

Health History: Diabetes _____ Cardiac _____ Lung _____ Psych_____ Seizures _____
*Confirmed COVID date _____ Other _____

Please share any further comments pertinent to your health:
_____
_____
_____
Name and Phone Number of Personal Physician
_____
_____
_____

List all Allergies:

Food_____ Medications_____Hay Fever_____
Insect bites/stings_____ Other_____
List any food or activity restrictions: _____
_____

Please list ALL medications (including over the counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time at camp. **IMPORTANT!! Keep all medication in the original and current packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.**

Medication	Dosage	Specific times taken each day	Purpose

Attach additional pages for more medications.

Authorization to treat: This health form is correct so far as I know, and I am able to engage in all camp activities except as noted on this form. If I cannot give consent, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for myself. I also authorize the camp nurse to administer treatment as necessary and to administer any medications prescribed by my physician as listed on this form.

Signature D

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