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 in 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

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_____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.
DPT Series _____ Tetanus Booster_____ Polio OPV (Sabin) _____
Rubella _____ Measles _____ Mumps _____ Hepatitis B _____ Hib _____
TB Test (latest) _____ Results _____ Varicella Chicken Pox _____
COVID Vaccine type: _____ Dates: _____ _____ _____ (attach copy)

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 regularly. 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, the name of the medication, the dosage, the frequency of administration and purpose.

Medication	Dosage	Specific times taken each day	Purpose

Attach additional pages if necessary.

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 Date

Camp Judah
2444 North Main St.
Warsaw, NY 14569
(585)786-2969
fax: (585)786-8249

campjudah.com
campjudah@gmail.com