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

NameGenderDate of Birth AddressCityStateZip PERSON TO CONTACT IN CASE OF EMERGENCY: 1.NameRelationship to camperPhone 2.NameRelationship to camperPhone Health Insurance Information:				
1.NamePhonePhone 2.NameRelationship to camperPhone				
1.NamePhonePhone 2.NamePhonePhone				
2. NamePhone				
Health Insurance Information:				
CarrierPolicy #				
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 dat applicable.	3S II			
DPT Series 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 Other: Diabetes Cardiac Lung Psych Seizures				
Please share any further comments pertinent to your health:				
Na	ne			
and Phone Number of Personal Physician				
·				
List all ALLERGIES:				
FoodHay Fever				
Insect bites/stingsOtherOtherOther				
List any food or activity restrictions:				
Do you have an epipen you plan to have with you at camp?				

Please list ALL medications (including over the counter or nonprescription drugs) taken regularly. Bring enough medication to last the entire time at camp.

<u>IMPORTANT!</u> (Please read) Keep all medication in the <u>original and current packaging/bottle</u> 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

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