



STAFF HEALTH HISTORY RECORD

SUMMER GAMES CAMP

Instructions: Adult staff, the following information is requested so that Summer Games Camp can better meet your physical, intellectual, and emotional needs. **No adult staff will be admitted to camp without this form.** Fill out the information requested. (Use the back of this form if additional space is required.) When completed, please submit to *Aliecia Zygadlo 43964 Elm Dr, Sterling Heights MI 48313.*

| | | | | | |
|----------------------------------|------------|------------|--------------------------|--------------------------|---------------|
| _____ | _____ | _____ | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Last Name | First Name | M.I. | Male | Female | Date of Birth |
| _____ | | | | | _____ |
| Home Address | | | | | Home Phone |
| _____ | | | | | _____ |
| City | State | Zip | Cell Phone | | |
| _____ | | | | | _____ |
| Emergency Contact's Last Name | First Name | M.I. | Relationship | Emergency Phone | |
| _____ | | | | | _____ |
| Emergency Contact's Home Address | | City | State | Zip | |
| _____ | | _____ | _____ | _____ | |
| Family Health Insurance Co. | | Contract # | Plan Code | Group # | |
| _____ | | _____ | _____ | _____ | |

***ATTACH PHOTOCOPY OF INSURANCE CARD**

Check the following: (Explain problem areas identified below on the back of this form including any current infectious diseases)

| | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Are you having any of the problems listed below? | Yes | No | | Yes | No |
| 1. Hay fever, asthma, or wheezing? | <input type="checkbox"/> | <input type="checkbox"/> | 7. Trouble with passing urine or bowel movements? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Eczema or frequent skin rashes? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Shortness of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Convulsions/seizures? | <input type="checkbox"/> | <input type="checkbox"/> | 9. Speech problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Heart trouble? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Menstrual problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Diabetes? | <input type="checkbox"/> | <input type="checkbox"/> | 11. Dental problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Frequent colds, sore throats, earaches? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Other? (Please detail on the back of this form) | <input type="checkbox"/> | <input type="checkbox"/> |

Operations or injuries: _____

Explain any special health, behavioral or emotional consideration(s): _____

Medications: needed or used (including Psychiatric)

| Name: | Frequency: | Dosage | Take at camp? (yes/no) |
|-------|------------|--------|------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Special conditions to watch for such as ALLERGIES (reactions to food, penicillin, other drugs), bedwetting, fainting, sleepwalking, etc.:

Should your activity be restricted because of any physical limitation or illness? ☐ Yes ☐ No If yes, please explain degree of restriction on back.

Immunizations: Are your immunizations up to date? ☐ Yes ☐ No

☐ **Medical Emergency Care Authorization:**

I hereby give permission to Summer Games Camp Inc. to secure emergency medical and surgical treatment and to provide routine, nonsurgical medical care, while I am attending camp. By signing below, I authorize care.

☐ **For Religious Exemption:**

I object to consent receipt of emergency medical or surgical treatment, by signing below I attest that I am in good health, and I assume the health responsibility for myself.

I certify that this information is true to the best of my knowledge.

Authorized Person's Signature: _____ Date: _____

ADDITIONAL MEDICAL INFORMATION:

A physical examination by a physician is **not required**. If you have had a physical within the past 12 months, you may attach a copy to this form.

Use this area for additional information from the front of this form:

CONFIDENTIAL GUIDANCE FOR CAMP STAFF: Please write below anything that might help the camp staff such as a change in the family (new baby, death, re-marriage, divorce, re-location, illness, etc.) or anything you feel is affecting your child physical or mental health either positively or negatively. Include how you feel your child is affected in his/her relationship with others. The more we know about you, the more helpful we can be.