TWIN PINES

Camp, Conference, and Retreat Center
3000 Twin Pine Road, Stroudsburg, PA 18360
Telephone: 570-629-2411 ~ Fax: 570-620-0664 ~ Email: staff@twinpines.org

SUMMER STAFF HEALTH FORM

Must be brought along when reporting for work.

IMPORTANT: Pease notify the camp if you have been exposed to any communicable diseases during the three weeks immediately prior to reporting to camp. Thanks for providing accurate information on this form.

Name_____ Birthdate_____ Age_____

Street Address_____ □ Male □ Female

City, State, Zip_____

Parent or Guardian_____ Home Phone_____

If the above is not available in an EMERGENCY, please notify:

1. Name_____ Phone_____

or Address_____

2. Name_____ Phone_____

Address_____

HEALTH HISTORY: (Check if applicable or give approximate date of last problem, if known.)

	Allergies:	**Diseases:**
_____ Ear Infections	_____ Hay Fever	_____ Chicken Pox
_____ Rheumatic Fever	_____ Ivy Poison, etc.	_____ Measles
_____ Convulsions	_____ Insect Stings	_____ German Measles
_____ Diabetes	_____ Penicillin	_____ Mumps
_____ Behavior	_____ Other Drugs	_____Asthma

Operations or Serious Injuries (dates)_____

Chronic or Recurring Illness_____

_____

Other Diseases or Details of Above_____

_____

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed camp activities, except as noted by me and/or the examining physician. In the event I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp personnel to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for the person named above.

Signed_____ Date_____

Date of Last Tetanus Booster (this must be complete; to be current this must have been within the last ten years.) _____

RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:

Any Food Restrictions or Allergies_____

Any Specific Activities to be Encouraged_____

Any Specific Activities to be Restricted_____

Any Limitations on Strenuous Activity_____

Any Limitation on Swimming or Diving_____

Any Special Medications (name them)_____ Is Parent Sending It? □ Yes □ No

Specific Written Directions for Any Medications Being Sent Along to Camp_____

_____

_____

Any Other Health Information That Would Be Helpful to Camp Medical Personnel_____

_____

_____

MEDICAL EXAMINATION: To Be Filled Out by a Licensed Physician.
This examination should be performed within three (3) weeks of arrival at camp. Examination is for determining fitness to engage in strenuous activities.

CODE FOR MARKING FORM: **OK** = Satisfactory **X** = Not Satisfactory **O** = Not Examined

Ht._____ Wt._____ B.P._____ Hgb. Test_____ Urinalysis_____

Eyes_____	Lungs_____	Allergies_____
glasses_____ contacts_____	Abdomen_____	_____
Ears_____	Hernia_____	_____
Nose_____	Extremities_____	General Appraisal_____
Throat_____	Posture (spine)_____	_____
Teeth_____	Skin_____	_____
Heart_____		

(For Females)

Has this person menstruated?_____ If so, is her menstrual history normal?_____

If not, has she been told about it?_____ Any special considerations?_____

_____

I have examined the person herein described and have reviewed his /her health history. It is my opinion that he/she is physically able to engage in any and all camp activities, except as noted above.

SIGNATURE OF EXAMINING PHYSICIAN_____ DATE_____

ADDRESS_____ PHONE_____