

**CAMP DYNAMITE  
STAFF HEALTH HISTORY FORM**

**CONTACT INFORMATION**

Staff Member's Name

Gender

DOB

Age at Camp

Legal Guardian Name (18 & Under)

Address

Relationship to Camper

Preferred Phone Numbers

Emergency Contact Name (Other than self)

Relationship to Camper

Preferred Phone Numbers

**MEDICAL INFORMATION**

Are you covered by family medical insurance?     Yes     No

Insurance Company Contact Number

Who is the policy holder?

**DIET**

Do you eat a special diet?     Yes     No

If so please provide the restrictions and reactions.

**RESTRICTIONS**

Do you have any physical restriction?     Yes     No

If so please explain and provide special needs.

**ALLERGY & ASTHMA**

Do you have any allergies?     Yes     No

If so please list all allergies whether food, medicines or environmental (insects stings, hay fever, etc.).

What is your reaction?

What medications do you take at home? Please provide.

Do you have asthma?     Yes     No    If so please send inhalers or nebulizers to camp.

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**MEDICATIONS**

Will you be taking any prescribed or over the counter medications at camp?     Yes     No

If so please provide a legible list of medications, reason for taking the medication and the frequency.

(Example - Tylenol 3, Back Pain, Twice a day by mouth)

**MEDICAL HISTORY QUESTIONNAIRE**

- |  |                           |                          |
|--|---------------------------|--------------------------|
| 1. Ever been hospitalized?                                   | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. Ever had surgery?   | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Have recurrent/chronic illnesses?                         | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. Had a recent infectious disease?                          | <input type="radio"/> Yes | <input type="radio"/> No |
| 5. Had a recent injury?                                      | <input type="radio"/> Yes | <input type="radio"/> No |
| 6. Had shortness of breath?                                  | <input type="radio"/> Yes | <input type="radio"/> No |
| 7. Have diabetes?  | <input type="radio"/> Yes | <input type="radio"/> No |
| 8. Had seizures?   | <input type="radio"/> Yes | <input type="radio"/> No |
| 9. Had headaches?  | <input type="radio"/> Yes | <input type="radio"/> No |
| 10. Wear glasses, contacts, or protective eyewear?           | <input type="radio"/> Yes | <input type="radio"/> No |
| 11. Had fainting or dizziness?                               | <input type="radio"/> Yes | <input type="radio"/> No |
| 12. Passed out/had chest pain during exercise?               | <input type="radio"/> Yes | <input type="radio"/> No |
| 13. Had mononucleosis ("mono") during the past 12 months?    | <input type="radio"/> Yes | <input type="radio"/> No |
| 14. If female, are there problems with periods/menstruation? | <input type="radio"/> Yes | <input type="radio"/> No |
| 15. Have problems with falling asleep/sleepwalking?          | <input type="radio"/> Yes | <input type="radio"/> No |
| 16. Ever had back/joint problems?                            | <input type="radio"/> Yes | <input type="radio"/> No |
| 17. Have a history of bedwetting?                            | <input type="radio"/> Yes | <input type="radio"/> No |
| 18. Have problems with diarrhea/constipation?                | <input type="radio"/> Yes | <input type="radio"/> No |
| 19. Have any skin problems?                                  | <input type="radio"/> Yes | <input type="radio"/> No |
| 20. Traveled outside the country in the past 9 months?       | <input type="radio"/> Yes | <input type="radio"/> No |

Please explain the reason and result of any yes questions. (Example - #9 Migraines - placed on medication)

**MENTAL, EMOTIONAL AND SOCIAL HEALTH**

- |  |                           |                          |
|--|---------------------------|--------------------------|
| 1. Have you ever been treated for ADD or ADHD?                                 | <input type="radio"/> Yes | <input type="radio"/> No |
| 2. Have you ever been treated for emotional, behavioral or an eating disorder? | <input type="radio"/> Yes | <input type="radio"/> No |
| 3. Have you seen or currently seeing a mental health professional?             | <input type="radio"/> Yes | <input type="radio"/> No |
| 4. Have you experienced a significant life changing event?                     | <input type="radio"/> Yes | <input type="radio"/> No |

Once again, please explain any yes answered questions.

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Are your immunizations up to date?  Yes    No

Are there any medical issues we missed?  Yes    No  
If yes please explain.

**LEGAL CONSENT FOR STAFF MEMBERS**

This health history is correct and accurately reflects the health status of myself. I am certifying that I am medically able to participate in all camp activities except as noted. I give permission to the physician selected by the camp to order x-rays, routine tests, and treatments related to the health of myself for both routine health care and in emergency situations. I give permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery on my behalf. I understand the information on this form will shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my health record from providers who treat me and these providers may talk with the program's staff about my health status.

I consent to emergency medical treatment on my behalf. I understand that Camp Dynamite assumes no liability for injuries or damages due to willful fault or negligence. I give consent to the administration of over the counter medications by a camp staff member as needed for minor aches, pains or accidents.

I consent to the use of any audio or visual records of the myself, without remuneration, to be used, distributed or displayed as agents of Camp Dynamite sees fit. I certify that the information in the registration packet is accurate and true.

Staff Member's Signature (18 & over)

Date

As the legal guardian of the minor staff member, I give permission for my child to participate as staff. I also consent to everything in the above mentioned legal consent and release.

Legal Guardian Signature

Minor Staff Members Name

Date