

Health History Form for Camp Staff (complete form every year)

*Because we want to support your ability to do your job well, please complete this form accurately and completely.

Return Completed Form to

Camp Glen Brook
35 Glen Brook Rd.
Marlborough, NH 03455

Questions?
603-876-3342

Name: _____ Date _____
First Name Middle Initial Last Name

Date of Birth: _____ Sex: _____
Month Day Year

Permanent Address: _____

Preferred Phone #: (_____) _____ E-mail: _____

Country of Residence: _____

Allergies: Check those that apply to you.

_____ I have no known allergies.

_____ I have an allergy to this food: _____ This causes anaphylaxis? Yes No
Describe what happens if you eat this food and how the reaction is managed:

_____ I am allergic to this medication/s: _____ This causes anaphylaxis? Yes No

_____ I am allergic to these substances: _____ This causes anaphylaxis? Yes No
Describe what happens if you eat this food and how the reaction is managed:

Nutrition: Our expectation is that staff set an example for campers by eating the provided menu. We can work effectively with some medically prescribed diets but cannot cater to individual food preferences. There are times when you might need to simply not eat a served item.

_____ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.

_____ I am a vegetarian of this type: Semi-vegetarian (no pork or beef) Vegan (no meats, eggs or dairy)
 Pesco (no pork, beef or chicken) Lacto-ovo (no beef, pork, chicken, seafood, or fish)

_____ I am lactose-intolerant. Be prepared to manage your intolerance using products such as Lactaid or food avoidance.

_____ I avoid _____ because of religious beliefs.

_____ I respond with an anaphylactic reaction when I eat this food: _____

Chronic Concerns: Check all that pertain to you and provide information about supportive health care.

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s): Asthma Headaches/Migraines Sleep problem Diabetes
 Difficult breathing Dysmenorrhea Fainting Surgery history Seizure disorder: _____

Back pain or injury Knee or ankle weakness Other: _____

Provide information about supportive healthcare needed for each checked item:

Immunization History: Provide the month & year for immunizations. Asterisked (*) immunizations must be current.

Immunization	Date — Month(s) & Year(s)	Immunization	Date — Month(s) & Year(s)
Tetanus Booster*	Current within 10 years:	Polio*	
Varicella* (Chicken Pox)		MMR (Mumps, Measles, Rubella)*	
Meningitis		Pneumococcal	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	DPT (diphtheria, tetanus, pertussis)*	
Hepatitis B		Hepatitis A	
Influenza			

_____ I am not fully immunized for religious reasons

General Physical History

- 1. Have you ever been hospitalized? Yes No
 Have you ever had surgery? Yes No
- 2. Have you ever passed out during or after exercise/physical exertion? Yes No
 Have you ever been dizzy during or after exercise/physical exertion? Yes No
 Have you ever had chest pain during or after exercise/physical exertion? Yes No
 Do you tire more quickly than your friends during exercise/physical exertion? Yes No
 Have you ever had high blood pressure? Yes No
 Have you ever been told that you had a heart murmur? Yes No
 Have you ever had racing of your heart or skipped heartbeats? Yes No
- 3. Have you ever been knocked out, fainted, or become unconscious? Yes No
 Have you ever had a seizure? Yes No
- 4. Have you ever had heat or muscle cramps? Yes No
 Have you ever been dizzy or passed out in the heat? Yes No
- 5. Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of your body areas?
 Yes No
- 6. Have you been in countries other than the United States in the past nine months? Yes No
 If yes, list the countries and the length of time spent in them.
 Country: _____ Dates: _____
 Country: _____ Dates: _____
 Country: _____ Dates: _____
- 7. Name of your physician: _____ Office Phone: (_____) _____
 Name of your dentist/orthodontist: _____ Office Phone: (_____) _____
- 8. Date of last health physical _____

Mental & Emotional Health Information

- A. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?
 If "yes" attach a statement that:
 - (a) Describes the concern and your management plan for addressing it while working at camp; and
 - (b) Describes the support needed from your work supervisor to compliment your plan.

