IVY LEAGUE DAY CAMP

732-446-7035 phone
732-446-5623 fax

140 Gordons Corner Road
Manalapan, NJ 07726

S T A F F   H E A L T H   F O R M

Directions: Please complete BOTH SIDES of this form.

Staff Name:____ Date of Birth ____________

Address ____ Age ________ Sex _____

City ____________________ State ______ Zip Code_______ Home Phone ____________

IN AN EMERGENCY PLEASE NOTIFY (someone close to camp who is available during the day)

1. Name_________________________
   Address _________________________
   City & State _________________________
   Relationship _________________________
   Home Phone _________________________
   Other Phone _________________________

2. Name _________________________
   Address _________________________
   City & State _________________________
   Relationship _________________________
   Home Phone _________________________
   Other Phone _________________________

CURRENT HEALTH ISSUES

(check and give details)

- ☐ Asthma
- ☐ Heart trouble
- ☐ Seizures
- ☐ Fainting Spells
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Allergy or reaction to any medicine, food, plant, animal or insect toxin.

Explain ___________________________
____

APPROVED FOR PARTICIPATION IN:

☐ All Activities including water activities and competitive Sports

Explain any restrictions or limitations below

____
____
____
____
____

Attach Recent Photo Here

<u>IMMUNIZATIONS</u> (required by the State)

Tetanus ______________ PPD ____________________

<u>MEDICAL HISTORY</u>

Date of most recent physical exam (month and year) ____________

Are you taking any medication? ☐ No ☐ Yes (explain) ______________________

Are you currently under medical care? ☐ No ☐ Yes (explain) ______________________

Do you currently have any health problems? ☐ No ☐ Yes (explain) ______________________

Has there been any surgery, illness, allergy or change in health status since the last complete physical exam?

☐ No ☐ Yes (Explain in the space below)

____
____
____
____
____

(OVER)

Physician's Name ________________________________ Phone ____________________

Address ____

Dentist's Name ________________________________ Phone ____________________

Address ____

Staff Social Security Number ____________________________________

Do you carry family medical/hospital insurance? ☐ No ☐ Yes-indicate carrier ____________________

Policy or group ______________________ Social Security # of Policy Holder ________________

CHECK ALL THAT CURRENTLY APPLY: (Explain in the space below)

Tetanus	☐	Chest, Lungs	☐	Hernia	☐
Deformity	☐	Heart	☐	Back, Limbs, Joints	☐
Immune Deficiency	☐	Murmur	☐	Serious Illness/Injury	☐
Surgery	☐	Rheumatic Fever	☐	Sleepwalking	☐
Skin, Glands	☐	Stomach, Bowels	☐	Behavioral Condition	☐
Eyes, Ears	☐	Kidneys, Urine	☐	Other:	
Wears Contact Lens/Glasses	☐	Infection	☐	____________	☐
Nose, Sinus, Tonsils	☐	Bed wetting	☐	____________	☐
Teeth	☐	Menstrual Problems	☐		
Dentures	☐	Migrain			
Bridge	☐				
Braces	☐				

Explain ____

____

____

TREATMENT

In the event of a minor medical emergency, the Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions, at her discretion:

Cepacol Lozenges/Spray	☐ No	☐ Yes	Acetaminophen (Tylenol)	☐ No	☐ Yes	Tums	☐ No	☐ Yes
Benadryl Spray	☐ No	☐ Yes	Benadryl Elixir/Tablets	☐ No	☐ Yes			

To the best of my knowledge, the medical history is correct and complete.

____ ____________________

Signature of Staff *or* Parent if staff member is under 18 years Date

To be completed for Staff members ***UNDER 18 YEARS OF AGE****:*

In the event I cannot be reached in an EMERGENCY, I hereby give permission to the Physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Parent/Guardian Name ____________________ Business (___)________________ Cell (___)________________

____ ____________________

Parent or Legal Guardian's Signature Date