

Camp Riverbend
 116 Hillcrest Rd.
 Warren NJ 07059

Date: _____

STAFF PERSONAL HEALTH AND MEDICAL RECORD

Staff Member Name: _____ Birth Date: _____
 Street Address: _____ Age: _____
 City, State, Zip: _____ Sex: _____

In case of emergency, notify:

1. Name: _____ Relationship: _____
 Street Address: _____ Home phone: _____
 City, State, Zip: _____ Other phone: _____

2. Name: _____ Relationship: _____
 Street Address: _____ Home phone: _____
 City, State, Zip: _____ Other phone: _____

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination <i>* If TD or DT, indicate in corner box</i>							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV) in corner box</i>							
MEASLES, MUMPS, RUBELLA (MMR)						Document below single antigen vaccine receipt, serology titers, or varicella disease history	
HAEMOPHILUS B (HIB)**							
HEPATITIS B						Hepatitis B	Date: _____ Titer: _____
VARICELLA						Varicella	Date: _____ Titer: _____
PNEUMOCOCCAL CONJUGATE**						Measles	Date: _____ Titer: _____
MENINGOCOCCAL						Mumps	Date: _____ Titer: _____
HEPATITIS A ***						Rubella	Date: _____ Titer: _____
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

Provisional Admission Attached – Date Granted _____ Medical Exemption Attached Religious Exemption Attached

TB Screening (Mantoux Text)			Chest X-Ray			Therapy	
Date	Date	Date	Date	Normal	Abnormal	Case <input type="checkbox"/>	Reactor <input type="checkbox"/>
Tested _____	_____	_____	_____	_____	_____	Date Started _____	
Read _____	_____	_____	_____	_____	_____	Date Completed _____	
Result (MM) _____	_____	_____	_____	_____	_____		

* REQUIRED MEDICAL EXEMPTION ** REQUIRED FOR DAY/CHILDCARE ENROLLEES (2 Months -5th Birthday only) *** NOT REQUIRED

People who were born before 1957 and cannot produce the above information will be considered adequately immunized. TB test must have been within the last year)

Do you have a history of food or other allergies Yes _____ No _____
 If yes, please describe: _____

Do you have a history of chronic or recurring illness? Yes _____ No _____
 If yes, what is the nature of illness? _____

Do you have any limitations/restrictions that would interfere with camp responsibilities? Yes _____ No _____
If yes, please explain: _____

What medications are you taking currently (prescription and over-the-counter): _____

When was your last physical exam? _____

Has there been any change in your health status since that date?

	Yes	No
Chronic/recurring illness	___	___
Hospitalization/surgery	___	___
Injury	___	___
Fracture/dislocation	___	___
Chest pain/palpitations	___	___
Asthma/lung disease	___	___
Heart Condition	___	___

Please comment on any "Yes" response: _____

To the best of my knowledge, this health history is correct and complete. I know of no reason to restrict (name of staff member) _____'s activity and give permission for participation in all activities except as specially noted herein. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to be hospitalized and secure proper treatment for myself or my child named above.

Date: _____
Signature of staff member: _____
Signature of parent/guardian if staff member is under 18 years old _____

=====

FOR CAMP USE ONLY

Reviewed by Nurse: _____ Date: _____