



**Please return to Camp Cobbossee as soon as possible:**

**Winter:** 17254 Gulf Pine Cir., Wellington, FL 33414 **Summer:** PO Box 299, Monmouth, ME 04259  
p: 800-473-6104 • f: 207-933-4560 • www.campcobbossee.com • info@campcobbossee.com

# STAFF HEALTH HISTORY FORM 2010

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_  
First Name Middle Initial Last Name Month Day Year

Permanent Address: \_\_\_\_\_

Preferred Phone #: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_ Country of Residence: \_\_\_\_\_

Your Contract Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Your Job Title: \_\_\_\_\_

International Staff: rate your ability to speak English. 0 1 2 3 4 5  
None Good Excellent

- Return this form to our camp office ASAP.
- Keep a copy of the completed form for your records; note changes that occur and inform us of any changes prior to your arrival.
- Notify the camp director if you are exposed to a communicable disease within three weeks of beginning your job.
- We expect you to arrive in good health and capable of doing the job for which you were hired.
- Information on this form is available to Health Center staff and your work supervisor(s).

**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:**

\_\_\_\_\_ 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. I can manage my intolerance using products such as Lactaid or food avoidance.

\_\_\_\_\_ I avoid \_\_\_\_\_ because of religious beliefs.

**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 condition     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:

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**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			

**Medication:** Camp Cobbossee prohibits staff and campers from keeping medications (prescriptions or not) in the cabins. Please provide the appropriate information below. **Domestic Staff:** Please register with **CVS Pharmacy** if you do require medication on a daily or as needed basis. **CVS Pharmacy** is a service that we use which will pre-package all medication that is in pill form. This service is provided at no additional charge. **International Staff:** Please bring enough medication to last the summer if you do require medication on a daily or as needed basis. Prescription meds **MUST** be in pharmacy containers with appropriate labels; other remedies must be in their original container. Please translate information into English.

\_\_\_\_\_ I do not take medication on a routine basis.      \_\_\_\_\_ I take routine medication (include vitamins) as noted below.

Name of Medication	Reason for Taking It	Dose Given & When	Date Started?
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	
		<input type="checkbox"/> Breakfast Dose: _____ <input type="checkbox"/> Evening Meal Dose: _____ <input type="checkbox"/> Bedtime Dose: _____ <input type="checkbox"/> Other: _____	

**General Physical History**

- 1. Have you ever been hospitalized? .....  Yes  No
- 2. Have you ever had surgery? .....  Yes  No
- 3. Have you ever passed out during or after exercise/physical exertion? .....  Yes  No
- 4. Have you ever been dizzy during or after exercise/physical exertion? .....  Yes  No
- 5. Have you ever had chest pain during or after exercise/physical exertion? .....  Yes  No
- 6. Do you tire more quickly than your friends during exercise/physical exertion? .....  Yes  No
- 7. Have you ever had high blood pressure? .....  Yes  No
- 8. Have you ever been told that you had a heart murmur? .....  Yes  No
- 9. Have you ever had racing of your heart or skipped heartbeats? .....  Yes  No
- 10. Do you have skin problems (itching, rashes, acne)? .....  Yes  No
- 11. Have you ever been knocked out, fainted, or become unconscious? .....  Yes  No
- 12. Have you ever had a seizure? .....  Yes  No
- 13. Have you ever had a stinger, burner, or pinched nerve? .....  Yes  No
- 14. Have you ever had heat or muscle cramps? .....  Yes  No
- 15. Have you ever been dizzy or passed out in the heat? .....  Yes  No
- 16. Have you ever sprained, strained, dislocated, fractured, broken, or had repeated swelling or other injuries to any of your body areas?  
 Yes  No If so, where?  Head  Shoulder  Thigh  Neck  Chest  Forearm  Shin/calf  
 Back  Wrist  Hand  Ankle  Elbow  Knee  Hip  Foot
- 17. Can you lift and carry 30 pounds (14 kilograms) at least ten times without assistance or discomfort? .....  Yes  No
- 18. Have you had chicken pox or are you immunized for chicken pox? .....  Yes  No
- 19. Have you had mononucleosis in the past nine months? .....  Yes  No
- 20. Do you have an uncorrected hearing problem? .....  Yes  No
- 21. Do you have an uncorrected vision (sight) problem? .....  Yes  No
- 22. Do you wear glasses or contacts or use protective eye wear? .....  Yes  No
- 23. Do you smoke and/or use other tobacco products? .....  Yes  No
- 24. Do you have any piercings? .....  Yes  No  
If so, where?  Ears  Eyebrow  Nose  Tongue  Belly Button  Nipple  Other: \_\_\_\_\_
- 25. Do you have any problems with your teeth? .....  Yes  No
- 26. 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: \_\_\_\_\_
- 27. For women: Do you have a menstrual problem (pain, irregularity, etc.)? .....  Yes  No  
Explain and/or provide more detail about the General Physical Health questions to which you responded "yes."

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of your physician: \_\_\_\_\_ Office Phone: (\_\_\_\_\_) \_\_\_\_\_

Name of your dentist/orthodontist: \_\_\_\_\_ Office Phone: (\_\_\_\_\_) \_\_\_\_\_

**Mental & Emotional Health Information**

- A. Have you been diagnosed with attention deficit disorder (ADD) or AD/HD. . . . .  Yes  No
- B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work? . . .  Yes  No
- C. Do you have an eating disorder that will impact your work? Type: \_\_\_\_\_ . . . .  Yes  No
- D. Do you have a learning disability that will impact your work? Type: \_\_\_\_\_ . . . .  Yes  No
- E. Do you have an emotional health concern that will impact your work? . . . . .  Yes  No
- F. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?  
 If "yes" to any question in this section, 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.

**Paying for Health Care:**

- There is no charge for health care provided by the camp's Health Center staff.
- Staff are financially responsible for health care provided by out-of-camp providers unless otherwise specified.
- If you will be using personal insurance while working at camp, it is your responsibility to know how to access and use that insurance. If your insurance requires pre-authorization, you should consider obtaining it prior to arriving at camp. **Make sure to bring your insurance card to camp AND attach a copy to this form.**

**Medical Insurance Information:**

Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Subscriber \_\_\_\_\_ Insurance Company Phone Number \_\_\_\_\_

**Emergency Contact:** Whom do you want us to contact in an emergency?

First Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to You: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to You: \_\_\_\_\_

**Authorization for Health Care:** Parental signature required for staff less than 18 years of age.

This health history is correct insofar as I know. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp Health Center staff in providing care to me and may be reviewed by work supervisor.

Signature of Staff Person: \_\_\_\_\_ Date: \_\_\_\_\_