girl scouts of northern california

Staff Health History Record

STAFF: *Complete form through Part VII: Patient Consent section on the back.*

PART I: STAFF RECORD

Name - Last, First, Middle Initial | Birth Date - MM/DD/YYYY

Home Address | City/State/Zip

Parent/Guardian Name | Day Time Telephone ( ) | Evening Phone ( ) | Cell Phone ( )

Parent/Guardian Name | Day Time Telephone ( ) | Evening Phone ( ) | Cell Phone ( )

PART II: EMERGENCY CONTACT IF PARENT/GUARDIAN CANNOT BE REACHED

Name | Day Time Telephone ( ) | Evening Phone ( )

Home Address | City/State/Zip | Relationship to Staff

PART III: HEALTH INSURANCE INFORMATION

Name of PHYSICIAN: ______________________________ Telephone: ( ) ______________________

Address of PHYSICIAN: ______________________________ City / State / Zip ______________________

Medical/Hospital INSURANCE CARRIER: ______________________ POLICY/GROUP NUMBER: ______________________

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.? ❒ Yes ❒ No

If yes, what ID number do you use? What is the HMO main phone number for emergencies? ( )

PART IV: ALLERGIES/ILLNESSES/INJURIES

Allergic Reaction: (Check those that apply and specify nature of allergic reaction) ❒ **Check here for no known allergies**

❒ Animals ______________ ❒ Hay Fever ______________ ❒ Medicines/Drugs ______________

❒ Pollen ______________ ❒ Food ______________ ❒ Insect Stings ______________

❒ Plants/Poison Oak ______________ ❒ Other (specify) ______________

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

❒ Asthma ______________ ❒ Diabetes ______________ ❒ Heart Defect/Disease ______________

❒ Musculoskeletal Disorder ______________ ❒ Bleeding/Clotting Disorders ______________ ❒ Ear Infection ______________

❒ Hypertension ______________ ❒ Seizures/Convulsions ______________ ❒ Mononucleosis ______________

❒ Skin Disease/MRSA ______________ ❒ Other (specify) ______________

Childhood Diseases: (Check those that apply and give appropriate dates)

❒ Chicken Pox ______________ ❒ Measles ______________ ❒ German Measles ______________

❒ Mumps ______________ ❒ Other (specify) ______________

Other Health Conditions: (Check those that apply)

❒Attention Deficit Disorder (ADD) ❒Down's Syndrome ❒Hearing Impairment ❒Nose Bleeds

❒Wears Glasses/Contacts ❒Bed Wetting ❒Emotional Disturbances ❒Menstrual Cramps

❒Sickle Cell Trait/Disease ❒Special Dietary Regimen ❒Dental Braces ❒Fainting

❒Motion Sickness ❒Sleep Disturbances ❒Visual Impairment ❒Autism Spectrum

List any current physical, mental or psychological health conditions requiring medical treatment, special restrictions or considerations: ____

____

List any dietary restrictions or special considerations: ______________________________

____

List any previous medical treatments, operations or serious injuries, provide dates: ______________________

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PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you **DO NOT** want to receive: ______

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____

Do you take any medications? (RX or Over The Counter)

❒ NO ❒ YES

If YES, do you require any medication that might impair your ability to perform the essential functions of your position? This information must be disclosed and discussed with the Health Staff.

❒ NO ❒ YES

Note: medications (both RX or Over The Counter) must be turned in and locked in the health center. Health Staff are available round the clock and you can access them from there at any time needed.

NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the name, address, dosage and frequency. Please label with name and dosage any over-the-counter drugs - anti-histamines, vitamins, etc.

PART VI: IMMUNIZATION HISTORY – REQUIRED I am providing a list of all medical immunization with the health history form OR I attest that all immunizations are current.

Vaccines	Date: Month / Year	Date: Month /Year
Diptheria, Tetanus and Pertussis- DTP, DTaP or any combination of DTP or DTaP with DT (tetanus and diphtheria)		
Tdap Booster		
Oral Polio (Sabin)* TOPV		
Injectable Polio (Salk)		
Measles, Mumps, Rubella (MMR)		
Varicella		
Hepatitis B		
Tuberculin test given		
Other:		

Based on your job description, list any condition that would limit full participation of camp activities in any way: ________________________

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Additional comments: ____

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PART VII: TREATMENT CONSENT

This health history is correct as far as I know, and I have permission to engage in all prescribed activities, except as noted by me and/or the physician. I am in good health. I give permission to receive treatment for routine medical and/or first aid needs, as outlined in the Treatment Protocols and for the administration of prescribed medications. In the event I cannot speak for myself in an emergency, I give permission to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to contact me or the emergency contact noted above, before taking this action.

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Signature of Staff Member **Date**