Place Current Photo Here

Position ______________

CV STAFF 2018 HEALTH AND MEDICAL RECORD

STAFF NAME______________________________ **BIRTHDATE**______________
HOME ADDRESS______________________________ **AGE**________ **SEX**__________
CITY/STATE/ZIP____________________ **PHONE**____________________ **SS #**______________
EMAIL______________________________ **Cell Phone**______________________

DOCTOR'S NAME______________________________ **CHART #**________ **PHONE**______________

EMERGENCY CALL INFORMATION (parent/spouse called first unless otherwise requested)
MOTHER/GUARDIAN______________________ WORK PHONE______________________
CELL PHONE______________________
FATHER/GUARDIAN______________________ WORK PHONE______________________
CELL PHONE______________________
SPOUSE ______________________ WORK PHONE______________________
CELL PHONE______________________

Additional emergency names and phone numbers (3 additional names **required** - neighbor, friends or relative)
1. NAME /RELATION______________________ HOME PHONE ______________________
WORK PHONE______________________ CELL PHONE______________________
2. NAME /RELATION______________________ HOME PHONE ______________________
WORK PHONE______________________ CELL PHONE______________________
3. NAME /RELATION______________________ HOME PHONE ______________________
WORK PHONE______________________ CELL PHONE______________________

EMERGENCY MEDICAL INFORMATION (to be completed by self, parent/guardian)
ALLERGY: (medicine, food, insect toxin, other)______________________________
Medication used for allergies______________________________
Allergy medication being sent to camp: YES______ NO______

HISTORY OF: Asthma________ Convulsions________ Diabetes________ High fevers________
*Other medical conditions*______________________________
Explain______________________________
Any condition requiring medication______________________________
Medications for above______________________________
Medications being brought to camp: YES______ NO______
Does staffer wear: glasses________ contact lenses________ braces________ hearing aide______

*If any medication is coming into camp, it must be accompanied by a note. The note should state the recipient's name, the medication name, amount to be given and time to be given. Prescription and "over the counter" medications **must** be in original, labeled bottles or containers. For prescription drugs, pharmacies will provide a duplicate empty bottle which is labeled and can be sent to camp with the medication. These rules apply to overnight and late stay medications as well as daily medications. **Everyone must complete the Medication Consent as per directions on that page (Page 3).**

AUTHORIZATION
In the event I or my child requires emergency medical care (as determined by the camp administration) while I/he/she is under camp jurisdiction, I authorize the doctor(s) and hospital to which I/my child is brought to perform all necessary emergency procedures and render treatment including the administration of anesthesia as necessary. I understand that attempts will be made to contact parents/guardians/spouse (or the emergency numbers listed on this form as necessary) before initiating this authorization.

Date__________ Employee /Parent/Guardian______________________________
(If staff member is under18 years of age)

Please return this completed form to: Camp Veritans, 225 Pompton Road, Haledon, New Jersey 07508 as quickly as possible.

CV STAFF 2018 HEALTH AND MEDICAL RECORD (continued)

Staff Name:____

Address____

Physician's Name______________________ ____________________**Phone Number**________________

MEDICAL HISTORY (to be completed and signed by doctor)

Date of Last Physical Exam______________________ *(Information based on P.E. within past 12 months)*

Height_______________ Blood Pressure______________ Vision ______________ (Pass/refer)

Weight_______________ Pulse______________ Hearing______________ (Pass/refer)

*** IMMUNIZATIONS REQUIRED – *Attach Immunization Record*

CURRENT OR PAST HISTORY:

	NO	YES	YEAR	DETAILS
Injury				
Skin				
Glands				
Eyes				
Ears				
Nose				
Teeth				
dentures				
bridge				
Chest				
Bones				

	NO	YES	YEAR	DETAILS
Deformity				
Stomach				
Bowels				
Hernia				
Kidney				
Bladder				
wetting				
GYN				
Heart				
murmur				
other				

Behavior
Neurologic
Contagious
Other

Physician's signature or Office Stamp____

***Please return this form to: Camp Veritans 225 Pompton Road, Haledon, New Jersey 07508**

Rev::1/18 lafB

Staff Medication Consent Form 2018

New Jersey State Law requires the use of a written consent form in order to dispense any medication in camp. This includes all over- the- counter medications (Tylenol, Advil/Motrin, decongestant, cough medicines, eye drops, etc.) as well as all prescription medications. This form **must be signed by both the parent and the doctor for minor staff members if you want to allow your child to be given ANY medication;** there can be **no exceptions** and **no** telephone (verbal) permission. This permission form will remain in effect for the camp season indicated (June-August). Any medication sent to camp must be in the original container appropriately labeled by the pharmacy or manufacturer. Adult Staff must complete and sign this form. A new form must be filled out for each new camp year.

Lee Ann Beck, R.N.

Name of Employee__________________________________

Prescription Medications

Name of Medication____ Dosage____________________
Reason for administration____
Time of administration____
Possible side effects____

Name of Medication_______________________________________ Dosage_____________________
Reason for administration____
Time of administration____
Possible side effects____

Over the Counter Medications

Acetaminophen/ Ibuprofen (circle appropriate medication) Yes__________ No____________
Dosage____
Reason for administration____

Pepto Bismol / Tums (circle appropriate medication) Yes______________ No________________
Dosage____
Reason for administration____

Other Medications____
Dosage_____________ Time of Administration (if applicable)______________________________
Reason for administration____
____

I authorize the camp nurse to administer the above medications as necessary. If employee is under 18 years of age, parent will be called prior to administration of medications.

****Employee (if over the age of 18)/ Parent/Guardian**_______________________________________
****Physician**____________________________________ **MD STAMP:**

****MUST BE SIGNED BEFORE ADMINISTRATION****

Staff Medical Insurance Card Information 2018

A copy of your medical insurance card is required for your medical form to be complete.

Staff Name: ___________________________________

Attach Copy of front of Medical Insurance Card here

Attach Copy of Back of Medical Insurance Card here