Place Current Photo Here

Position _____

CV STAFF 2019 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)

Couples count as only one contact.

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_____

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.

CAMP VERITANS

ACCREDITED

CV STAFF 2019 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

Is there any medical condition or medication that will effect performance of the job requirements camp staff? Yes_____ No_____
Details_____

Physician's signature or Office Stamp_____

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

Medication Consent Form 2019

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 2019

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