Return this completed HEALTH information form to: Laketrails Base Camp P.O. Box 810 Warroad, MN 56763 Your Contract Dates: _____ to _____ **Emergency Contact:** Who do you want us to contact in an emergency? Contact: _____ Phone: _____-_____-_____ Alternate Contact: _____ Phone: _____-_____-_____	Name: _____ First Middle Last Sex: ☐ Male ☐ Female Date of birth: _____ Permanent Address: _____ Street Address _____ City State/Country Zip/Code Is this your first year as a staff member? . . . . . . ☐ No ☐ Yes

- Return this form to our camp office at least four weeks prior to your arrival. People hired within four weeks of their start date should not send this form; bring it with you and give it to the Health Center staff at camp.
- Notify the Camp Director if you are exposed to a communicable disease within three weeks of beginning your job.
- The camp expects that you arrive in good health and capable of performing the essential functions of your position. If you have concerns regarding this, speak with the Camp Director prior to arrival.
- Information on this form is available to Health Center staff and your work supervisor(s) as necessary.

If you have questions about our camp health services,
please call our office.

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 are exposed to these medications or substances and how the reaction is managed:

_____

_____

_____

Nutrition: Our expectation is that staff set an example for campers by eating the provided meal. We work with some medically prescribed diets, such as gluten-free and lactose intolerant, but cannot cater to individual food preferences. Discuss concerns with the Camp Director prior to the start of camp.

_____ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.
_____ I am a standard vegetarian.
_____ I am a vegan. (no meats, seafood, eggs, or dairy)
_____ I am lactose intolerant /have lactose allergy.
_____ Other special dietary needs: _____

Chronic and/or Recent Concerns: Check all that pertain to you and provide information about supportive healthcare.

_____ I have no chronic health concerns or significant health concerns within the past three years.
_____ I have the following chronic or recent health concern(s):

☐ Asthma	☐ Headaches, Migraines	☐ Sleep problem	☐ Depression
☐ Diabetes	☐ Difficulty breathing	☐ History of head injury	☐ Anxiety
☐ Fainting	☐ Surgical history	☐ Seizure disorder:	☐ ADHD
☐ Back pain or injury	☐ Knee or ankle weakness	☐ Arm/shoulder/wrist weakness	

☐ Other mental health concern/diagnosis: _____
☐ Other physical concerns: _____

Immunization History:

Date (month/year) of your most recent tetanus immunization: _____

Medication: All medication must be locked securely in the camp Health Center unless in the immediate possession/control of the user. A private medication locker is available to all staff.
NOTE: Health Center staff will ask about your medication(s) to determine if the use (or non-use) of such medication will impair completion of the essential functions of your job. They may also ask about medication when you seek healthcare. Providing additional information about your medication is voluntary.

General Physical History: If you answer "Yes" to any of these questions, please provide more information at the end of this section.

1.	Have you ever been hospitalized?	☐ Yes	☐ No
2.	Have you ever passed out during or after exercise?	☐ Yes	☐ No
3.	Have you ever been dizzy during or after exercise?	☐ Yes	☐ No
4.	Have you ever had chest pain during or after exercise?	☐ Yes	☐ No
5.	Do you tire more quickly than your friends during exercise?	☐ Yes	☐ No
6.	Have you ever had high blood pressure?	☐ Yes	☐ No
7.	Have you ever had a racing heartbeat or skipped heartbeats?	☐ Yes	☐ No
8.	Have you ever been knocked out or become unconscious?	☐ Yes	☐ No
9.	Have you ever had a seizure?	☐ Yes	☐ No
10.	Have you ever had a stinger, burner, or pinched nerve?	☐ Yes	☐ No
11.	Have you ever had heat or muscle cramps?	☐ Yes	☐ No
12.	Have you ever been dizzy or passed out in the heat?	☐ Yes	☐ No

13. 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 ☐ Hand, Elbow ☐ Other: _____
☐ Neck ☐ Chest ☐ Back
☐ Hip ☐ Knee ☐ Foot, Ankle

14. Have you been in countries other than the United States in the past nine months? . . . . . ☐ Yes ☐ No

If yes, list the countries and the time spent in them.

Country: _____ Dates: _____

Country: _____ Dates: _____

Country: _____ Dates: _____

Your supervisor expects that staff who have chronic health concerns are capable of performing the essential functions of the job for which they have been hired. If you have any concerns, please speak with the Camp Director.

Use the space below to 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 _____

Paying for Health Care

- There is no charge for healthcare provided by the camp's Health Center staff.
- You are financially responsible for healthcare provided by all other providers.
- If you will be using personal insurance while working at camp, know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

Authorization for Healthcare:

This health history is correct. 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's Health Center staff in providing care to me and may be reviewed by my work supervisor(s). I give permission to the physician selected by the camp to provide emergency treatment including, but not limited to X-rays, routine tests and treatment, and/or hospitalization if necessary.

Signature of Staff Person: _____ Date: _____

Signature of Parent (if needed): _____ Date : _____

Staff Member STOP Here.

Documentation by Health Center Staff

Date/Time _____ Initial _____

Screening has been conducted per camp protocol and findings noted below:

A.	Any signs/symptoms of illness or injury upon arrival?	NO	YES as noted below
B.	Any history of exposure to communicable diseases?	NO	YES as noted below
C.	Any additions, corrections, or clarifications to information on this form?	NO	YES as noted below
D.	As necessary, medication has been reviewed with the healthcare provider?	NO	YES as noted below
E.	Any signs/symptoms of head lice?	NO	YES as noted below

Screening Done By: _____

_____

_____

_____

_____

_____

_____

_____

_____

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EXIT NOTE: Check one of the following:

- ☐ Left camp this day with no reported illness or injury symptoms.
  Client's exit date: _____
- ☐ Left camp this day with the following problem/concern:

_____

Summary of nursing instructions provided: _____

Exit note completed by: _____