



2022 Staff Health History Form

Return this completed form to Empower Camp by May 1, 2022 via email to secretary@empcamp.com. Empower Camp expects that you arrive to camp in good health and capable of performing the essential functions of the volunteer position. If you have concerns, please speak to the Camp Director prior to arrival.

Staff Name (Last, First): _____

Date of Birth: _____

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

First Contact: _____ Phone: _____ Relationship to you: _____

Alternate Contact: _____ Phone: _____ Relationship to you: _____

Medical History: Has/Does participant have....

- | | | |
|--------------------------------------|--------|---|
| 1. Recent injury or illness? | Yes No | 6. Explain "Yes" answers and anything else we may need to know about your health: |
| 2. Ever had seizures or convulsions? | Yes No | _____ |
| 3. Diagnosed with heart condition? | Yes No | _____ |
| 4. Asthma? | Yes No | _____ |
| 5. Diabetes? | Yes No | _____ |

Immunization History: Date (Month/Year) of your most recent tetanus or TDAP immunization: _____

Dietary Needs: Our expectation is that staff set an example for campers by eating the provided meals. We work with some medically prescribed diets such as lactose intolerant and will do our best to cater to individual food preferences. Describe any dietary restrictions or considerations or allergies:

Allergies: Do you have any allergies? (include all allergies including food, medicinal, skin/contact, environmental, or other).

Allergy	Reaction	Treatment

*If you are required to carry an epi pen, you must bring the epi pen and are responsible for carrying it with you.

Medications: List all medications (including over the counter or non-prescription medications) being taken. Bring enough medication to last the entire duration of camp. Medications must be in original packaging that identifies the medication, dosage, and frequency of administration. **ALL MEDICATIONS INCLUDING OVER-THE-COUNTER MUST BE GIVEN TO THE NURSE. UNDER NO CIRCUMSTANCES MAY A VOLUNTEER STAFF KEEP MEDICATIONS IN THEIR POSSESSION.**

Medication	Dosage	Time Given	Reason for medication	Special Instructions

COVID-19 Vaccine: The volunteer is fully vaccinated against COVID-19 per NYS guidelines.

Date of 1st dose: ___/___/___ Date of 2nd Dose: ___/___/___ Date of booster shot: ___/___/___

Text (716-218-9376) or email (secretary@empcamp.com) a copy of your COVID-19 vaccine card.

Insurance: Insurance Company _____ Subscriber Name _____

Policy Number _____

Text (716-218-9376) or email (secretary@empcamp.com) a copy of your insurance card. Copy both sides of the card so information is readable.

Paying for Health Care:

- There is usually 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 volunteering 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.

Medication: I understand & agree that all medication must be locked securely with the Nurse unless discussed prior with the Nurse & Director.

Authorization for Healthcare: This health history is correct to the best of my knowledge. I am capable of performing the essential functions as a camp volunteer and participating in assigned work duties as noted on this form. I understand and agree that, I retain primary responsibility for managing my health status while at camp. I agree to inform Empower Camp of any changes that might impact my participation. I understand my health information will be used by the camp's health center staff in providing care to me and shared with camp staff on a "need to know" basis and may be reviewed by my work supervisor(s), and that it is solely my responsibility to inform Empower Camp of any relevant medical information about myself

Signature of Volunteer Staff Person _____

Date _____