5040 State Road 67 N
Martinsville, IN 46151
(756) 342-2915
www.bradwoods.org

Health History Form for Seasonal Employees

Name: ____
First Middle Last

Permanent Address: ____
Street Address

____
City State/Country Zip/Code

Phone Number: ____

If you have questions about our camp health services, please call or email Tommy Gardner at tggardne@indiana.edu or 765-349-5120

- *Return this form to camp office at least four weeks prior to your arrival.*
- *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.*

Allergies: *Our expectation is that, if needed, the employee will have an EpiPen® and know how to use it if anaphylaxis is a concern.*

Food Allergies:	Describe reaction and management of reaction:
______________________	____
______________________	____
______________________	____

Medication Allergies:	Describe reaction and management of reaction:
______________________	____
______________________	____
______________________	____

Other Allergies:	Describe reaction and management of reaction:
______________________	____
______________________	____
______________________	____

Nutrition: *Our expectation is that staff set an example for campers by eating the provided meal. We will work with most medically prescribed diets, such as gluten-free and lactose intolerant, but may not be able to cater to all 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 vegetarian of this type:

- ☐ Semi-vegetarian (no pork or beef)
- ☐ Ovo (no meats, fish, seafood, or dairy)
- ☐ Pesco (no pork, beef, or chicken)
- ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
- ☐ Lacto (no meats, fish, seafood, or eggs)
- ☐ Vegan (no meats, seafood, eggs, or dairy)

_____ I do not eat _______________ products because of religious beliefs.

Immunization History:

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

Have you completed the immunizations that were required for school attendance? ☐ Yes ☐ No

Chronic Concerns:

Check all that pertain to you and provide information about supportive healthcare. 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 contact your supervisor.

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s):

☐ Asthma	☐ Headaches, Migraines	☐ Sleep problems
☐ Diabetes	☐ Difficulty breathing	☐ Dysmenorrhea
☐ Fainting	☐ Surgical history	☐ Seizure disorder: ____________________
☐ Back pain or injury	☐ Knee or ankle weakness	☐ Other: ____________________________

Medication:

While sleeping in camper cabins, medications must be locked securely in the Lockable Closet or Health Center.

_____ I do not take any medications.

_____ I take medications that the use (or non-use) could impair the ability to perform the essential functions of this job.

Please List: ____

General History:

If you answer "Yes" to any of these questions, 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 ☐ Leg ☐ Neck ☐ Chest
☐ Arm, hand ☐ Ankle ☐ Back ☐ Hip ☐ Foot

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: ____________________________

15. Have you ever had an eating disorder? . . . . ☐ Yes ☐ No
16. Have you ever had emotional difficulties for which professional help was sought? . . . . ☐ Yes ☐ No

Use the space below to explain and/or provide more detail about the General Health questions to which you responded "Yes."

______ ____

______ ____

______ ____

______ ____

Physician

Name of your physician: ____ Office Phone (_________)_______________________

Name of your dentist/orthodontist: ____ Office Phone (_________)_______________________

Paying for Health Care

- 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.

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

First Contact: ____ Preferred Phone: (______)_______________ Relationship to You: ________________

Alternate Contact: ____ Preferred Phone: (______)_______________ Relationship to You: ________________

Authorization for Healthcare: *Parental signature required for staff under 18 years of age.*

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).

Signature of Staff Person: ____ *Date:* _________________________________

Signature of Parent (if needed): ____ *Date :* _________________________________