CAMP MATOAKA
HEALTH INFORMATION UPDATE FOR STAFF

ALL staff are required to fill out the online Health History Form and a Health Care form. This is a requirement of the American Camp Association, and no health care can be given without a completed form.

1. **Staff must complete a new Health History Form each summer. The Health Form must be signed by a licensed physician.**

2. You are required to have an examination by a licensed physician every two years. Therefore, if you have had an examination by a licensed physician since **August 2016**, you may use a copy of that examination and send it to the Camp Matoaka Office. For returning staff that had an examination by a licensed physician last year for their Health form, it can be used again this year. You **still** have to complete the online health form.

3. The completed Health History and Examination form is required on camp by **June 1st**. Any staff member who starts their contract without a completed form will have to schedule an exam with our health care provider and pay a fee of $75. We cannot give any health care without a completed 2018 form.

4. The information required is confidential and is no way discriminatory or used to screen out staff. The health forms are only reviewed by the Health Care staff. Please be honest and fill out the form completely. In the event of an emergency it could save your life.

INFORMATION FOR INTERNATIONAL STAFF

International staff should be aware that there is no flat prescription charge in America. We strongly advise international staff to bring enough of any medication they take regularly or on an "as needed basis." Not only can it be very expensive to refill a prescription, some items may not be available in America. In addition, please note that some over the counter medicines in your country may only be available in America with a doctor's prescription. Anyone traveling with needles (i.e., diabetics) need to have a covering prescription from their Doctor authorizing their use.

COUNSELOR HEALTH INSURANCE INFORMATION

Although all employees are covered under the camp's Workers' Compensation Insurance Policy, there are gaps in health coverage. All "worker's comp" policies cover employees for **work related accidents and injuries only.** You are covered for all medical related services, treatment and accidents when you are on or off campus while in the capacity of working for. This leaves open the areas of sickness and off duty accidents and injuries. For example, if on your day off or night out you are injured and need medical treatment, or you get sick (not related to work) and need hospitalization, **Workers Compensation** does not cover you for these types of health care. We strongly recommend you have some form of personal health care coverage while at camp. Many times you can extend your school coverage over the summer months or you can be covered under a parent's health plan, if it has that option. **(Please note: this is for American Counselors only – International Staff hired through an agency, i.e., CCUSA, Wild Packs, etc.) have their own insurance.** We do provide ample free time for staff participation at the camp's many facilities. During this "off duty" participation, worker's compensation insurance does not cover you, as it is not part of your assigned duties for the job.

We ask for the name and number of your health insurance carrier on the health form. During an emergency, this number can be given to the hospital and medical care will be prompt. Without adequate proof of insurance, medical care can be delayed or withheld. We insist that all camp activities are executed under totally safe conditions and that sound judgment is exercised. We are proud of our safety record and wish to keep Matoaka a healthy and safe place for campers and staff alike.

The health of our staff and campers is of primary concern at Matoaka. To facilitate our medical care process, we ask your cooperation in providing us the necessary information regarding your personal health insurance policy. Remember, you must submit the completed online Health Form to Camp prior to June 1st. Thank you in advance for your help.

Health History Form for Camp Matoaka Staff

Please complete this form accurately and completely. It must be signed by a health care professional who has given you a physical within the last year.

Return Completed Form to

Before May 15th
Camp Matoaka
PO Box 812789
Wellesley, MA 02482
wendy@matoaka.com

After May 15th
Camp Matoaka
One Great Place
Smithfield, ME 04978
wendy@matoaka.com

Name: _____
First Name Middle Initial Last Name

Date of Birth: _____ Sex: _____
Month Day Year

Permanent Address: _____

Preferred Phone #: (_____)_____ E-mail: _____

Country of Residence: _____

Your Contract Start Date: _____ End Date: _____

Your Job Title: _____

- *Return this form to our camp office by June 1st.*
- *Provide a copy of your health insurance card.*
- *Keep a copy of the completed form for your records; note changes that occur and inform the healthcare provider of these changes.*
- *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 doing the job for which you were hired.*
- *Information on this form is available to Health Center staff and your work supervisor(s).*

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 eat this food and how the reaction is managed:

_____

_____

Nutrition: *Our expectation is that staff set an example for campers by ea ting the provided menu. W e can work effectively with some medically prescribed diets but cannot cater to individual food preferences. There are times when you might need to simply not eat a served item.*

_____ 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) ☐ Vegan (no meats, eggs or dairy)
☐ Pesco (no pork, beef or chicken) ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
_____ I am lactose-intolerant. *Be prepared to manage your intolerance using products such as Lactaid or food avoidance.*
_____ I avoid _____ because of religious beliefs. *[Insert this if appropriate: Camp kitchens are not kosher.*]
_____ I respond with an anaphylactic reaction when I eat this food: _____

Chronic Concerns: *Check all that pertain to you and provide information about supportive health care.*

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s): ☐ Asthma ☐ Headaches/Migraines ☐ Sleep problem ☐ Diabetes ☐ Difficult breathing ☐ Dysmenorrhea ☐ Fainting ☐ Surgery history ☐ Seizure disorder: _____ ☐ Back pain or injury ☐ Knee or ankle weakness ☐ Other: _____

Provide information about supportive healthcare needed for each checked item:

_____

_____

_____

Immunization History: *Provide the month & year for immunizations. Asterisked (*) immunizations must be current.*

Immunization	Date — Month(s) & Year(s)	Immunization	Date — Month(s) & Year(s)
Tetanus Booster*	Current within 10 years:	Polio*	
Varicella* (Chicken Pox)		MMR (Mumps, Measles, Rubella)*	
Meningitis		Pneumococcal	
Pertussis Booster (Whooping Cough)	Recommended Update at 12 years:	DPT (diphtheria, tetanus, pertussis)*	
Hepatitis B		Hepatitis A	
Influenza			

Medication: *Bring enough medication to last or bring your written prescription to order a refill. Prescription meds MUST be in pharmacy containers with appropriate labels; other remedies must be in original container. International Staff: translate information to English.*

_____ I do not take medication on a routine basis.

_____ I take routine medication (include vitamins) as noted below.

Name of Medication	Reason for Taking It	Dose Given & When	Date Started?
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	
		☐ Breakfast Dose: _____ ☐ Evening Meal Dose: _____ ☐ Bedtime Dose: _____ ☐ Other: _____	

Name of your physician: _____ Office Phone: (_____)_____

Address of your physician: _____

Signature of your physician (indicating that you've had a physical within two years of the start of your employment and that you are in good health and able to perform the functions of your job):

_____ Date: _____

General Physical History

1. Have you ever been hospitalized? ☐Yes ☐No

   Have you ever had surgery? ☐Yes ☐No

2. Have you ever passed out during or after exercise/physical exertion? ☐Yes ☐No

   Have you ever been dizzy during or after exercise/physical exertion? ☐Yes ☐No

   Have you ever had chest pain during or after exercise/physical exertion? ☐Yes ☐No

   Do you tire more quickly than your friends during exercise/physical exertion? ☐Yes ☐No

   Have you ever had high blood pressure? ☐Yes ☐No

   Have you ever been told that you had a heart murmur? ☐Yes ☐No

   Have you ever had racing of your heart or skipped heartbeats? ☐Yes ☐No

3. Do you have skin problems (itching, rashes, acne)? ☐Yes ☐No

4. Have you ever been knocked out, fainted, or become unconscious? ☐Yes ☐No

   Have you ever had a seizure? ☐Yes ☐No

   Have you ever had a stinger, burner, or pinched nerve? ☐Yes ☐No

5. Have you ever had heat or muscle cramps? ☐Yes ☐No

   Have you ever been dizzy or passed out in the heat? ☐Yes ☐No

6. 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 ☐ Thigh ☐ Neck ☐ Chest ☐ Forearm ☐ Shin/calf
   ☐ Back ☐ Wrist ☐ Hand ☐ Ankle ☐ Elbow ☐ Knee ☐ Hip ☐ Foot

   Can you lift and carry 30 pounds (14 kilograms) at least ten times without assistance or discomfort? ☐Yes ☐No

7. Have you had chicken pox or are you immunized for chicken pox? ☐Yes ☐No

8. Have you had mononucleosis in the past nine months? ☐Yes ☐No

9. Do you have an uncorrected hearing problem? ☐Yes ☐No

   Do you have an uncorrected vision (sight) problem? ☐Yes ☐No

   Do you wear glasses or contacts or use protective eye wear? ☐Yes ☐No

10. Do you smoke and/or use other tobacco products? ☐Yes ☐No

11. Do you have any piercings? ☐Yes ☐No

    If so, where? ☐ Ears ☐ Eyebrow ☐ Nose ☐ Tongue ☐ Belly Button ☐ Nipple ☐ Other: _____

12. Do you have any problems with your teeth? ☐Yes ☐No

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

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

    Country: _____ Dates: _____

    Country: _____ Dates: _____

14. For women: Do you have a menstrual problem (pain, irregularity, etc.)? . . . . . .☐Yes ☐No

Explain and/or provide more detail about the General Physical Health questions to which you responded "yes."

_____

_____

_____

Mental & Emotional Health Information

A. Have you been diagnosed with attention deficit disorder (ADD) or AD/HD. . . . . ☐Yes ☐No

B. Do you have a psychiatric diagnosis such as depression, OCD, panic/anxiety, bipolar disorder that will impact your work? . . . ☐Yes ☐No

C. Do you have an eating disorder that will impact your work? Type: _____ . . . . ☐Yes ☐No

D. Do you have a learning disability that will impact your work? Type: _____ . . . . ☐Yes ☐No

E. Do you have an emotional health concern that will impact your work? . . . . . ☐Yes ☐No

F. During the past year, have you seen a professional about mental/emotional concerns that will impact your work?

If "yes" to any question in this section, attach a statement that:

(a) Describes the concern and your management plan for addressing it while working at camp; and

(b) Describes the support needed from your work supervisor to compliment your plan. Refer to the Essential Functions of your job, available **[insert location**], if there are questions.

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

First Contact: _____ Phone: (_____) _____

Relationship to You: _____

Alternate Contact: _____ Phone: (_____) _____

Relationship to You: _____

Authorization for Health Care: This health history is correct insofar as I know. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I give the Camp Matoaka Health Care team permission to treat me.

Signature of Staff Person: _____ Date: _____