**OUB Staff Health History**

OUB holds all health information privately. Information is shared only with the Camp Director and Medical Officer except on a need-to-know basis to keep you safe, healthy and secure.

Documentation required to accompany this health form:

Copy of immunization record

Copy of insurance card

**Staff Information:**

Name:

Address:

Gender: Age: Birth Date: Transgender?

**Emergency Contact**

Name:

Address:

Phone: Work Ph:

Email:

**Alternate Emergency Contact**

Name:

Address:

Phone: Work Ph:

Email:

**Physician Contact**

Physician’s Name:

Phone #:

Date of last physical exam by a physician:

Activities restricted due to physical reasons or order by physician:

**Health Record**

Please enter **c** for Current, or **p** for Past History next to each condition. Leave blank if not applicable. If Other, please explain.

**Conditions:**

Ear infections Frequent Colds Sleep Walking

Sinusitis Hypertension Seizures/Epilepsy

Urinary Tract Inf. Bronchitis Bleeding Disorder

Fainting Heart Defect Constipation

Diabetes Mononucleosis Photophobic

Stomach Upsets Athletes Foot

Other:

**Diseases:**

Mumps Chicken Pox Ger. Measles

Measles Infectious Dis. Whooping Cough

Other:

**Allergies:**

Asthma Hay Fever Poison Ivy

Bee Stings Penicillin Sulfa

Other:

Food Allergies:

If you have an allergy, please state the allergen, the amount of allergen that can cause a reaction, and explain type of reaction.

Environmental Allergies:

If you have an allergy, please state the allergen and type of reaction:

Do you need to carry an EpiPen or asthma inhaler? YES NO

Do you have any special health considerations? If Yes, explain.

Operations or serious injuries (include dates):

Disabilities and chronic or recurring illnesses:

Have you been exposed to or have any current infectious diseases, such as Hepatitis A?

Dietary modification or special diet:

**Insurance**

Do you carry medical/hospital insurance? YES NO

If so indicate Carrier:

Policy #: Group #:

**PLEASE SUPPLY A COPY OF YOUR INSURANCE CARD WITH THIS FORM**

**Medication**

List any prescription drugs or nonprescription drugs and medications you take currently:

Name Dosage Frequency

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Medications must be in original pharmacy containers showing name of drug, dosage, frequency and doctor’s name. Please be aware that we need the original BOX for EYE DROPS with the pharmacy instructions. If you do not have the box with the proper label you must have written documentation from your physician in lieu of the label from the pharmacy. All prescription and over-the-counter medications will be stored and dispensed by the Medical Officer. **NO MEDICATION CAN BE DISPENSED UNLESS IN THE ORGINAL PHARMACY CONTAINER WITH THE PROPER DOCUMENTATION FOR DOSAGE AND THE DOCTOR’S CONTACT INFORMATION IS PROVIDED. IF YOUR DOCTOR HAS CHANGED THE DOSAGE, YOU MUST PROVIDE WRITTEN DOCUMENTATION FROM THE PHYSICIAN FOR US TO DISPENSE MEDICATION CONTRARY TO THE INSTRUCTIONS ON THE CONTAINER.**

**Permission To Treat For Routine Treatment & Over-The-Counter Medications**

I hereby give permission for the OUB Camp Medical Officer to provide non-surgical, routine medical care for myself.

This includes:

* Routine health care
* Administer medications if necessary
* Order x-rays, routine tests, and treatments if necessary
* Release medical records necessary for insurance purposes
* Provide or arrange related transportation

Medications may include but are not limited to:

* Tylenol or similar preparation for headaches or earaches
* Pepto Bismol, Tums, Mylanta or generic preparation for upset stomach
* Immodium for diarrhea
* Ibuprofen for sprains, strains, inflammation, menstrual cramps
* Calamine lotion or similar preparation for poison ivy/rashes
* Benadryl for severe itching

Dosages will be administered according to directions on the container unless physician directs otherwise. **This form covers one year from date printed below.**

Printed Name

Staff Person’s Signature Date

If you have other information or concerns, please list them here:

If there is a religious objection to consenting to receipt of emergency medical or surgical treatment, you shall submit a written statement to the effect that you are in good health and that you assume your own health responsibility.

**To Enter Camp:**

State law prohibits a director from admitting a staff person without a record of 1 dose of each of the following vaccinations: Measles, Mumps, Rubella, Polio, DPT

DPT - diphtheria, tetanus, pertussis (Whooping Cough)

DT - Diphtheria, tetanus

Td - Tetanus, diphtheria (adult)

Immunization Record (Please indicate most recent date for each):

DPT Measles

MUMPS Chicken Pox (Varicella)

HIB (haemophilus influenza b) TB test

Hepatitis B Tetanus

Meningitis

If immunization is against your religious beliefs, you must sign an exemption form provided by the State of Michigan and present it to the Health Officer.

If you take medication regularly, it must be given by the Medical Officer. No one is allowed to carry medication with them or keep it in their tent.

All medication must be in the original pharmacy labeled containers showing your name, the name of the medication, the dosage, frequency, and the doctor’s name.

**This Section Must be Completed for Attendance**

I submit that this information is true to the best of my knowledge. I release and discharge Opportunities Unlimited for the Blind and its agents from any damages that may arise directly or indirectly from my participation in this camp.

Medical Release

In the event of an emergency and I am unresponsive, I give permission to the physician or hospital selected by the camp administration, to hospitalize, secure proper anesthesia, order injection, surgery, and do whatever else appears medically necessary.

Name of Staff (print):

Staff Person’s Signature Date