

732-446-7035 phone  
732-446-5623 fax

**IVY LEAGUE DAY CAMP**  
140 Gordons Corner Road  
Manalapan, NJ 07726

**STAFF HEALTH FORM**

Directions: Please complete BOTH SIDES of this form.

Staff Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_

**IN AN EMERGENCY PLEASE NOTIFY** (someone close to camp who is available during the day)

1. Name \_\_\_\_\_  
Address \_\_\_\_\_  
City & State \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Other Phone \_\_\_\_\_

2. Name \_\_\_\_\_  
Address \_\_\_\_\_  
City & State \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Other Phone \_\_\_\_\_

**CURRENT HEALTH ISSUES**

(check and give details)

- Asthma
- Seizures
- Diabetes
- Allergy or reaction to any medicine, food, plant, animal or insect toxin.
- Heart trouble
- Fainting Spells
- High Blood Pressure

Explain \_\_\_\_\_  
\_\_\_\_\_

**APPROVED FOR PARTICIPATION IN:**

- All Activities including water activities and competitive Sports
- Explain any restrictions or limitations below

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Attach Recent Photo Here**

**IMMUNIZATIONS** (required by the State)

Tetanus \_\_\_\_\_ PPD (Tuberculosis) \_\_\_\_\_

**MEDICAL HISTORY**

Date of most recent physical exam (month and year) \_\_\_\_\_

Are you taking any medication?  No  Yes (explain) \_\_\_\_\_

Are you currently under medical care?  No  Yes (explain) \_\_\_\_\_

Do you currently have any health problems?  No  Yes (explain) \_\_\_\_\_

Has there been any surgery, illness, allergy or change in health status since the last complete physical exam?

No  Yes (Explain in the space below)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Staff Social Security Number \_\_\_\_\_

Do you carry family medical/hospital insurance?  No  Yes-indicate carrier \_\_\_\_\_

Policy or group \_\_\_\_\_ Social Security # of Policy Holder \_\_\_\_\_

**CHECK ALL THAT CURRENTLY APPLY:** (Explain in the space below)

- |                            |                          |                    |                          |                        |                          |
|----------------------------|--------------------------|--------------------|--------------------------|------------------------|--------------------------|
| Tetanus                    | <input type="checkbox"/> | Chest, Lungs       | <input type="checkbox"/> | Hernia                 | <input type="checkbox"/> |
| Deformity                  | <input type="checkbox"/> | Heart              | <input type="checkbox"/> | Back, Limbs, Joints    | <input type="checkbox"/> |
| Immune Deficiency          | <input type="checkbox"/> | Murmur             | <input type="checkbox"/> | Serious Illness/Injury | <input type="checkbox"/> |
| Surgery                    | <input type="checkbox"/> | Rheumatic Fever    | <input type="checkbox"/> | Sleepwalking           | <input type="checkbox"/> |
| Skin, Glands               | <input type="checkbox"/> | Stomach, Bowels    | <input type="checkbox"/> | Behavioral Condition   | <input type="checkbox"/> |
| Eyes, Ears                 | <input type="checkbox"/> | Kidneys, Urine     | <input type="checkbox"/> | Other:                 |                          |
| Wears Contact Lens/Glasses | <input type="checkbox"/> | Infection          | <input type="checkbox"/> | _____                  | <input type="checkbox"/> |
| Nose, Sinus, Tonsils       | <input type="checkbox"/> | Bed wetting        | <input type="checkbox"/> | _____                  | <input type="checkbox"/> |
| Teeth                      | <input type="checkbox"/> | Menstrual Problems | <input type="checkbox"/> |                        |                          |
| Dentures                   | <input type="checkbox"/> | Migrain            |                          |                        |                          |
| Bridge                     | <input type="checkbox"/> |                    |                          |                        |                          |
| Braces                     | <input type="checkbox"/> |                    |                          |                        |                          |

Explain \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**TREATMENT**

In the event of a minor medical emergency, the Camp Nurse has my permission to administer the following over-the-counter medications according to the label instructions, at her discretion:

- |                        |  |                         |  |      |  |
|------------------------|--|-------------------------|--|------|--|
| Cepacol Lozenges/Spray | <input type="checkbox"/> No <input type="checkbox"/> Yes | Acetaminophen (Tylenol) | <input type="checkbox"/> No <input type="checkbox"/> Yes | Tums | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Benadryl Spray         | <input type="checkbox"/> No <input type="checkbox"/> Yes | Benadryl Elixir/Tablets | <input type="checkbox"/> No <input type="checkbox"/> Yes |      |  |

To the best of my knowledge, the medical history is correct and complete.

\_\_\_\_\_  
 Signature of Staff or Parent if staff member is under 18 years

\_\_\_\_\_  
 Date

*To be completed for Staff members UNDER 18 YEARS OF AGE:*

In the event I cannot be reached in an EMERGENCY, I hereby give permission to the Physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

Parent/Guardian Name \_\_\_\_\_ Business (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
 Parent or Legal Guardian's Signature

\_\_\_\_\_  
 Date