

Valley Mill Camp Staff Health Form
15101 Seneca Road, Germantown, Maryland 20874
To be filled out by parent or guardian of minor

Staff Name _____ DOB _____ Sex ___ Age ___
Email: _____ Home #: _____ Cell #: _____
Home Address: _____

Staff Under 18 Years of Age Only

Parent Name(1) _____ Parent Name(2) _____
Work # (1): _____ Work # (2): _____ Cell # (1): _____ Cell # (2): _____
E-mail(1) _____ Email (2) _____

Emergency Contact: _____

Home #: _____ Work #: _____ Cell #: _____

Family Physician(required): _____ Phone #: _____

Date of last physical exam ___/___/___

Health History - Optional

- | | | | | |
|--|---|--|--|-----------------------------------|
| <input type="checkbox"/> Frequent Ear Infections | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Bleeding/Clotting Disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Psychiatric Treatment | |
| <input type="checkbox"/> Other _____ | | | | |

Do you have any significant, or chronic medical conditions we need to know about? If yes, please describe:

Allergic Reactions (Check all that apply)

- Hives Anaphylaxis Nausea Trouble Breathing Itching Local Swelling

Other: _____

PRN Medications for minors: I give permission to Valley Mill Camp Staff to Administer the following medications to my child as needed (please check all that apply):

___ Tylenol ___ Motrin/Advil ___ Benadryl ___ Other

Insurance Information:

Are you covered by family medical/hospital insurance? Yes No

If so, carrier of Plan Name _____ Group # _____

(Please See Other Side)

Staff Name: _____

Provide date (month/year) of your last Tetanus shot (DTP) (do not leave blank) _____

Immunization Information for Staff Under 18 years old.

Are you attending a Maryland School private or public? For Minors:

Yes, Provide the name of the Maryland school: _____

(See Other Side)

No, If your child is attending a school outside of Maryland, please attach a record of immunizations signed by a doctor confirming that the child has received all immunizations as required by Maryland DHMH, Recommended Childhood Immunization Schedule. *See:* www.EDCP.com for immunization information.

Is your child exempt from any immunizations on medical, or religious grounds?

Yes, Provide a copy of Maryland Department of Health and Mental Hygiene Immunization Certificate from either a licensed physician indicating that immunization is medically contraindicated, or the parent or guardian indicating that they object to immunizations for religious reasons.

No

Please describe any limitation or restriction on your child's activities:

This history is correct as far as I know, and the person herein described has permission to engage in all prescribed camp activities except as noted. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for my child as named above. This completed form may be photocopied for trips out of camp.

Signature of parent/guardian _____ Date ___/___/___ (if staff is under 18 yrs old)

Signature of Staff _____ Date ___/___/___

Thank You.

