Cohutta Springs Youth Camp Staff Health History Form

Please complete this form and **scan and email to campinfo@gccsda.com** or **fax to 706-625-3684** or mail to CSYC, PO Box 12000, Calhoun, GA 30703
(This is an ACA requirement.)

Legal Name:		Preferred Name
Social Security #	Birthdate: _____/_____/_____	Day/Cell Phone ( )

General Health History: Check "Yes" or "No" if you have or had a history of the following:

1. Asthma/wheezing ☐ Yes ☐ No
2. Athlete's Foot ☐ Yes ☐ No
3. Back or joint problems ☐ Yes ☐ No
4. Bedwetting ☐ Yes ☐ No
5. Communicable (Infectious) Disease ☐ Yes ☐ No
6. Concussion ☐ Yes ☐ No
7. Diabetes ☐ Yes ☐ No
8. Diarrhea/constipation ☐ Yes ☐ No
9. Ear Infections/Ear Tubes (circle) ☐ Yes ☐ No
10. Eye Glasses/Contacts (circle) ☐ Yes ☐ No
11. Fainting or dizziness ☐ Yes ☐ No
12. Frequent Sore Throats ☐ Yes ☐ No
13. Headaches ☐ Yes ☐ No
14. Head Injury ☐ Yes ☐ No
15. Head Lice ☐ Yes ☐ No
16. Heart Condition ☐ Yes ☐ No
17. Passed out or chest pain during exercise ☐ Yes ☐ No
18. Recurrent/chronic illnesses ☐ Yes ☐ No
19. Mononucleosis in past 12 months ☐ Yes ☐ No
20. Seizure Disorder ☐ Yes ☐ No
21. Sinusitis ☐ Yes ☐ No
22. Skin problems ☐ Yes ☐ No
23. Sleep problems or Sleepwalking ☐ Yes ☐ No
24. Sprain, Strain, Dislocation or other Injury ☐ Yes ☐ No
25. Stomach Upsets ☐ Yes ☐ No
26. Other_____

Please explain "Yes" answers in this space, noting the number of the questions. If more space is needed attach to form.

List any hospitalizations, Surgeries or Broken Bones:

Date	Hospitalization/Surgery/Broken Bones	Explanation

Mental, Emotional, and Social Health: Check "Yes" or "No" if you have:

1. Ever been treated for attention deficit disorder (ADD) or attention deficit/hyperactivity disorder (AD/HD)? ☐ Yes ☐ No
2. Ever been treated for emotional or behavioral difficulties or an eating disorder? ☐ Yes ☐ No
3. Ever had a psychiatric diagnosis such as depression, OCD, panic/anxiety, or bipolar disorder? ☐ Yes ☐ No
3. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
4. Had a significant life event that continues to affect your life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, survived a disaster, others)

Please explain "Yes" answers in this space, noting the number of the questions. If more space is needed attach to form.

Medications/Vitamins/Natural Remedies:

☐ I am **not** taking any daily medications.
☐ I am taking the following medications:

List prescription medications currently taking(Any psychotropic drugs must be at the therapeutic level – 3 months minimum use.)

Medication Name*	Dose	Frequency	Reason	What happens if dose is missed?
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		
		☐ Breakfast ☐ Dinner ☐ Other ☐ Lunch ☐ Bedtime _____		

Staff Health History Information

Staff Name_____
First Last

Allergies:

☐ No known allergies

☐ I am allergic to: ☐ Food ☐ Medicine ☐ Environment (insect stings, hay fever, etc.) ☐ Other

List all Allergies:	Reaction

Immunization History

Provide the month and year for each immunization. Starred (*) immunizations must be current. Copies of immunizations forms from health-care providers or state or local government are acceptable; please attach to this form.

Immunization	Dose 1 Month/Year	Dose 2 Month/Year	Dose 3 Month/Year	Dose 4 Month/Year	Dose 5 Month/Year	Most Recent Dose Month/Year
Diptheria, tetanus, pertussis* (DTaP) or (TDaP)						
Tetanus booster* (dT) or (TdaP)						
Mumps, measles, rubella* (MMR)						
Polio* (IPV)						
Haemophilus influenza type B (HIB)						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella Chicken Pox ☐ Had chicken pox Date:						
Meningococcal meningitis (MCV4)						
Tuberculosis (TB) Test	Date:		☐ Negative	☐ Positive		

If doctor advises, may Tetanus immunization be administered? ☐ Yes ☐ No

If you have not been fully immunized, please sign the following statement:

☐ *I understand and accept the risks from not being fully immunized.*

_____

Signature or Parent/Guardian's Signature if staff member is under 18 years of age. Date

This health history is correct and accurately reflects the health status of the person to whom it pertains. I release the conference and camp management from liability in case of serious injury or death while participating in activities not related to my job description or work assignments.

_____

Signature of Staff **Date**

_____

Parent/Guardian's Signature if staff member is under 18 years of age. Date

Please Note: Staff employment includes limited accident insurance while on camp premises.
Health insurance remains the family's responsibility, i.e. flu, earaches, insect bites, and other personal health issues.

Health Screening – To be completed at camp by Health Services:

Any signs of illness upon arrival? ☐ Yes ☐ No

Recent exposure to communicable disease? ☐ Yes ☐ No

Additions/corrections to health history form? ☐ Yes ☐ No

Any signs of injury upon arrival? ☐ Yes ☐ No

Any signs of head lice? ☐ Yes ☐ No

Currently taking Medications? ☐ Yes ☐ No

Explain "Yes" answers in space below- Continue on back if more space is needed.

Nurse Signature_____ Date/Time: _____