

PRIMARY HEALTH CARE PROVIDERS – Please provide the names and phone numbers of your home physicians.

Primary Care _____ Phone _____
Orthodontist _____ Phone _____
Dentist _____ Phone _____
Mental Health Provider _____ Phone _____

WHAT HAVE WE FORGOTTEN TO ASK? Please provide any additional information about your health, which was not discussed on this form. Attach another sheet as necessary.

PAYING FOR HEALTHCARE:

- There is usually no cost for healthcare provided by the camp’s healthcare team (Physician and Registered Nurses), except for medications prescribed for you by the physician at camp. (e.g. Antibiotics for strep throat, etc.)
- Staff members are financially responsible for healthcare provided by out-of-camp providers such as dentists, X-rays, Emergency Room visits, etc.
- You are responsible for knowing how to access your health insurance while working at Camp. Bring your insurance ID card with you as well as attaching a photocopy to this form. Obtain pre-authorization for out-of-state use if your insurance requires this. The local hospital is Bridgton Hospital, 10 Hospital Drive, Bridgton, ME 04009. Their phone number is 207-647-6000.
- **CANADIAN STAFF** – Please note that healthcare in the United States is very different than in Canada. Provincial health care plans are NOT accepted at the local hospitals. For your own financial safety, obtain Travel Health Insurance before you leave for Camp. Blue Cross / Blue Shield is recommended.

AUTHORIZATION FOR HEALTHCARE

Parent signature is only required for staff under 18 years of age.

This health history is correct as far as I know. I declare that I am capable of performing the essential functions of my job and that I am able to participate in assigned activities except as noted on this form. I understand my health information will be used by Camp Cedar’s healthcare staff in providing care to me and may be reviewed by the camp directors.

I understand that I am financially responsible for all medications, any medically required examinations or diagnostic tests prescribed for me that are not covered by Worker’s Compensation. I authorize Camp Cedar to release any records necessary for insurance purposes and to obtain my health information from other providers when it pertains to my immediate care.

In the event of an emergency where I am unable to give consent, I hereby give permission to the physician selected by Camp Cedar to hospitalize, secure proper treatment for, and to order injection anesthesia, or surgery for me.

Signature

Date

Printed Name

Signature of Parent (if employee is under 18 years of age)

Date

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Please complete pages 1 & 2 and return to Camp by June 1st.

Your medical provider should complete Page 3 and it can be sent to Camp separately.

Name of Employee

Date of Birth

Dear Medical Provider,

You are being asked to recommend an employee for participation in a seven week, sleep-away children’s summer camp program. Camp Cedar is a summer camp for boys aged 8-15 years, located in Casco, Maine. The 87-acre campus is hilly and with few paved walkways. Physical demands of staff usually require much walking during daylight, dusk and nighttime visibility. Physical endurance requirements vary on job role and function, but most staff should be able to walk 1-2 miles carrying 10-15 pounds without need for rest. Lifeguards will be expected to be able to swim 200 yards in under 10 minutes. Sports and activity staff will need to perform athletically per their sport, which usually entails running, quick turning / pivoting and jumping. If you require any further information about Camp Cedar or our program before making a recommendation for this employee to participate, please feel free to contact us at: 617-277-8080 during the winter/spring.

After June 1st, we may be contacted at: phone 207-627-4266, fax 207-627-4152.

IMMUNIZATION HISTORY – Please provide the month and year for each immunization or attach another sheet.

Immunization	Dose 1	Dose 2	Dose 3	Dose 4
DTP: Diphtheria, Tetanus, Pertussis				
Td: Tetanus Booster		Must be current within last 5 years		
MMR: Measles, Mumps, Rubella		Measles booster required prior to grade 7		
IPV/OPV: Polio				
HepB: Hepatitis B				
Hib: H. influenza, type B				
VZ: Varicella				
TB Skin Test (Indicate positive or negative result)				

BASELINE DATA

 Weight Height Temperature Heart Rate Resp. Rate Blood Pressure

MEDICAL RECOMMENDATION

Based on the information presented to me and upon my examination of this person, I recommend him or her for camp participation. To the best of my knowledge, he or she has not been exposed to a communicable disease within the last 30 days of my examination.

 Signature

 Date

 Printed Name

 Phone

 Address