

EMPLOYEE LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH (MM/DD/YYYY)
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HOME ADDRESS	CITY	STATE	ZIP CODE	MOBILE PHONE
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PERMANENT ADDRESS (OR PARENTS)	CITY	STATE	ZIP CODE	PHONE NUMBER
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SOCIAL SECURITY NUMBER	NAME OF INSURANCE CARRIER	ADDRESS	POLICY NUMBER
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EMERGENCY CONTACT INFORMATION:

FIRST CONTACT: _____ PHONE: _____ CELL: _____

ALTERNATE: _____ PHONE: _____ CELL: _____

ALLERGIES – Please list any allergies to medications, foods, insect stings or environmental stimuli. PLEASE describe the reaction you have when exposed to these allergens. Make special note of any anaphylactic reactions – those that require an EPI Pen.

MEDICATIONS – Please list ALL medications you take daily. We ask for a list of your medications here in case of emergency. This information is kept confidential amongst the medical staff at camp. Attach another sheet if necessary.

Medication	Dose	Frequency (how often a day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CHRONIC HEALTH STATES – Please check all that apply. Attach a separate note to describe any condition that requires special attention by the health care team at camp.

- I have no chronic health concerns.
- I have the following chronic health concerns:
 - Asthma or Allergies Seizure Condition Diabetes
 - Headaches Sleep Problems Back Pain or Injury
 - Knee or Ankle Weakness Surgery in the last year Fainting or Dizziness
 - Frequent Colds / Infections Menstrual Disturbances
 - Gastrointestinal Disturbances Heart or Heart Rhythm Disturbances
- Are there any other health concerns of which you would like us to be aware?

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

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