



Camp AmeriKids, Inc.
 88 Hamilton Avenue • Stamford, CT 06902
 Phone (203) 658-9500 • Fax (203) 658-9615

2012 STAFF HEALTH FORM

This form must be filled out in its entirety and returned to Camp AmeriKids by June 29th, 2012. All Health Forms are kept confidential.

GENERAL INFORMATION

Name: _____ Male Female

Date of Birth: _____ Age: _____

Address: _____

Phone: _____ Alternate Phone: _____

**** EMERGENCY CONTACT ****

Name: _____ Relation: _____

Phone: _____ Alternate Phone: _____

PAST MEDICAL HISTORY: (PLEASE ANSWER ALL QUESTIONS)

YES	NO	CONDITION	EXPLAIN
		Asthma	
		Bleeding/clotting disorder	
		Diabetes	
		Ear/sinus problems	
		Fainting spells	
		GI problems (abdominal, digestive)	
		Heart defects/murmur	
		Heart disease (CHF, CAD, MI)	
		HIV	
		Hypertension	
		Infectious disease (Hepatitis, etc.)	
		Kidney disease	
		Learning disorder (ADHD, ADD)	
		Menstrual problems (female only)	
		Muscular/skeletal condition	
		Psychiatric/psychological	
		Seizures	
		Sickle cell disease	
		Sleep disorder (sleep apnea)	
		Stroke/TIA	
		Thyroid disease	
		Other	

PHYSICIAN'S PHYSICAL EXAM FORM CONTINUED:

Past Surgical History: (Please list)

Have you been hospitalized in the past 5 years? If so, when & why: _____

Do you smoke? Yes No

Current Medications: _____

Drug Allergies: _____

IMMUNIZATION DATES

Mandatory: Date of immunization or blood test indicating immunity is required! You may attach laboratory results indicating Measles/Mumps/Rubella immunity. (Please note, if you were born before 1957 you are considered immune and do not need to provide a date or blood test.)

* Measles/Mumps/Rubella _____

Strongly Recommended

DPT/dT _____ PPD _____
Hepatitis B _____ Chickenpox vaccine _____
(or history of Chickenpox)

PHYSICAL EXAMINATION -- To be completed by a physician

(1) Satisfactory (2) Not Satisfactory (3) Not Examined

Height: _____ Weight: _____ BP _____ HR _____
Eyes: _____ Glasses: _____ Contacts: _____
Ears: _____ Hearing: _____ Right: _____ Left: _____
Heart: _____ Lungs: _____ Abdomen: _____ Hernia: _____
Extremities: _____ Skeletal: _____ Skin _____
Restrictions: _____
Recommendation: _____
The above named person is in satisfactory condition and may engage in all activities except as noted. I have found this person to be physically and emotionally healthy.
Date: _____ Examining Physician: _____
Telephone: _____ Print Name: _____
State License In: _____ License Number: _____
Address: _____

PLEASE RETURN TO:
Camp AmeriKids
88 Hamilton Avenue - Stamford, CT 06902
Fax (203) 658-9615



HIPAA FORM

Form is to be completed by Volunteer

Authorization to Release Protected Health Information

I, _____, HEREBY AUTHORIZE AND DIRECT the CAMP AMERIKIDS, INC. Camp Physician TO USE OR DISCLOSE MY PROTECTED HEALTH INFORMATION (as defined herein) to the Camp AmeriKids Camp Director as is deemed necessary by the director or the Camp Physician for the safe conduct of Camp AmeriKids programs.

In addition, I authorize the Camp Physician to request, secure and use information regarding any prior and ongoing health condition and any prior and ongoing care and treatment from all health care providers holding such information (my "Protected Health Information") including, but not limited to, history and physical examination, Admission and discharge summaries; operative reports; progress notes and nursing notes; laboratory reports; radiology reports; immunization records; billing summaries; consultation reports; pathology reports; psychological and psychiatric assessments; and medications.

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases, including HIV/AIDS, this information will be included as part of my Protected Health Information.

I understand that the Camp Physician may not condition treatment or eligibility to participate in the Camp AmeriKids program on my signing this authorization.

I understand that this authorization is intended for use or disclosure of my Protected Health Information to the extent of and as permitted by the Standards for Privacy of Individually Identifiable Health Information (the so-called "Privacy Rule") issued by the U.S. Department of Health and Human Services to implement the requirement of the Health Insurance Portability and Accounting Act of 1996 ("HIPAA"). I have been given an opportunity to inquire and request information to my satisfaction regarding the requirements of the above law and regulations.

I understand that this authorization will expire automatically on the later of 90 days from the date hereof or the end of the camp period, and I also understand that I may cancel and revoke this authorization at any time effective upon my delivering written notice thereof to the Camp Physician except to the extent there has already been use or disclosure in reliance on this authorization.

(Signature of Individual or Legally Guardian)

Social Security Number: _____

Date of Birth: _____

Today's Date: _____