

# Buckingham Browne & Nichols Summer Day Camp

Employee

## Employee Health Form

Mail to: BB&N Summer Camp, Attn: Summer Camp Director, 80 Gerry's Landing Road, Cambridge, MA 02138

Phone: 617-800-2195 Fax: 617-492-0102

BB&N Summer Day Camp requires that all employees provide documentation of a complete health history and an annual physical examination within the twelve months preceding the opening of camp.

Please fill out the complete health history and have a licensed provider complete the last page of this form.

All campe employees **MUST** submit a full immunization history.

Employee's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Are you over 18 yo? \_\_\_\_\_

### I. Complete Health History

Check YES or NO if you have experienced any of the concerns listed. If YES, describe.

Health Concerns	Yes	No	Comments - Treatments and appropriate dates
Cardiac Disease			
Seizures/Neurological Disorder			
Diabetes/Metabolic Disorder			
Blood Disorder			
Hospitalizations/Surgery			
Asthma/Respiratory Disorder			
Chronic Illness			
Visual Deficit/Eye Disorder			
Hearing Deficit/Ear Disorder			
Speech Deficit/Throat Disorder			
Digestive Disorder/Diet Restriction			
Orthopedic Disorder/Activity Restriction			
Menstrual/Genitourinary Disorder			
Chicken Pox			
Mononucleosis			
Psychological Concerns			
Attention Deficit Disorder			
Eating Disorders/Compulsions			
Suicide Gestures			
Other			

### ALLERGY HISTORY

Do you have any allergies? (Circle one) YES NO

If "Yes," please document allergy, typical response and treatment plan.

ALLERGEN	Typical Reaction	Treatment Plan

VALIDATION OF HEALTH HISTORY and RELEASE CONSENT: I do hereby confirm that the health information provided here is accurate and honest. I give consent for information relevant to my safety to be released on a need-to-know basis.

Signature of Employee \_\_\_\_\_

Date \_\_\_\_\_

If Employee is under 18 yo: Signature of Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

## II. Physical Examination by a Licensed Provider

Please have the Licensed Provider complete this form or a form supplied by the Licensed Provider may be attached to this form.

I have examined \_\_\_\_\_ on \_\_\_\_\_.

### IMMUNIZATION HISTORY

Please record the dates (month/year) of basic immunizations and most recent booster.

VACCINES	Dates			
DPT				
Td				
OPV/IPV				
MMR				
Hib				
Hepatitis B				
PPD/Mantoux				
Varicella				
Other				

### PHYSICAL EXAMINATION

Please indicate "YES" if individual's examination is *within normal limits* or "NO" if exam is of concern.

If "NO" is checked, please describe condition.

Height \_\_\_\_\_ Weight \_\_\_\_\_ Pulse \_\_\_\_\_ Respiration \_\_\_\_\_ Blood Pressure \_\_\_\_\_

SYSTEM	YES	NO	Comment
General Appearance			
Skin			
Eyes/Vision			
Ears/Hearing			
Nose			
Mouth/Teeth			
Cardiovascular			
Lungs			
Abdomen			
Genitourinary			
Musculoskeletal			
Neurologic			
Development			
Other			

### RECOMMENDATIONS WHILE AT CAMP

- Does the individual have any activity restrictions? YES NO Describe \_\_\_\_\_
- Does the individual have any dietary restrictions? YES NO Describe \_\_\_\_\_
- Will the individual be receiving medications while at camp? (Prescription or OTC) YES NO

(If "YES," please list all medications the individual will take while at camp. A medication order form must be completed for each medicine the individual will receive. Please use one form per medicine.) \_\_\_\_\_

### VALIDATION OF EXAMINATION

In my opinion, the above individual may participate in an activecamp program with the noted restrictions.

Licensed Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Telephone \_\_\_\_\_ FAX/Email \_\_\_\_\_

**In order to ensure the quickest receipt of this document please return to the following address.** Employee  
BB&N Summer Day Camp, **Attn: Summer Camp Director**, 80 Gerry's Landing Road, Cambridge, MA 02138