 FORM DUE: July 1st

LABCC – **STAFF** SUMMER CAMP HEALTH HISTORY FORM

❒ Counselor ❒ Specialist: _____ ❒ Kitchen ❒ Other: _____

Staff Member: _____ _____ ❒ Male ❒ Female

Last First Middle

Birth date: _____/_____/_____ Age at camp date: _____

Month Day Year

Home Address: _____

Street Address City State Zip Code

Emergency contact person in case of illness or injury (authorized to approve treatment):

Name: _____ Relationship: _____ Home: ( )_____ Cell: ( )_____

Work: ( )_____ Email: _____

HEALTHCARE PROVIDERS:

Primary physician(s): _____ Phone: ( ) _____

MEDICAL INSURANCE INFORMATION:

This individual is covered by family medical/hospital insurance: ❒ YES ❒ NO

Insurance Company: _____ Policy #: _____

Subscriber: _____ Insurance Company Phone: ( ) _____

The following health history is correct, as to the best of my knowledge, and I attest that I am physically and mentally capable to attend camp and participate in all camp activities. Furthermore, I maintain routine physical/medical examinations and follow-up as advised by my physician. **Authorization for Treatment:** I hereby give permission to the medical personnel selected by the camp director to order X-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for myself. In the event I cannot be contacted in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization. **The LABCC does not maintain any independent insurance for periods before, during, and after the camp program period, and is not responsible for any medical expenses incurred by campers or staff members, which are not covered by his/her family health insurance policy.**

Photo & Talent Release: I hereby assign and grant to the Los Angeles Buddhist Coordinating Council (LABCC), the right and permission to use and publish the photographs/film/video tapes/electronic representations and or sound recordings made of me this date by the LABCC and I hereby release the LABCC from any liability from such use and publication. I hereby authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the LABCC and I specifically waive any right to any compensation I may have for the foregoing.

Signature:	**Date:**

Include a copy of both sides of insurance card below

Submit Forms to Medical Staff Member or mail to Jim Matsushita 4019 W. 179th St., Torrance, CA 90504

 FORM DUE: July 1st

Staff Name: _____ Birth date: _____/_____/_____
Last First Month Day Year

ALLERGIES:

Please indicate only **TRUE** food and drug allergies and type of allergic reaction.
If no allergies, please check respective box.

Food Allergies: ❒ No known food allergies
(LABCC is unable to accommodate gluten allergies)
Type of food: Type of Reaction:
1. _____ _____
2. _____ _____

Drug Allergies: ❒ No known drug allergies
Medication: Type of Reaction:
1. _____ _____
2. _____ _____

Environmental Allergies: ❒ No known environmental allergies
(ie, bee stings, hay fever)
Allergen: Type of Reaction:
1. _____ _____
2. _____ _____

MEDICAL HISTORY:

Do you currently have or ever been treated for any of the following conditions:

Yes	No	Condition	Explain / Details
❒	❒	Asthma / COPD (if yes, MUST bring inhalers)	
❒	❒	Diabetes	
❒	❒	High blood pressure	
❒	❒	Heart disease (ie, CHF, CAD, MI)	
❒	❒	Stroke/TIA	
❒	❒	Bleeding disorders, sickle cell disease	
❒	❒	Ear/sinus problems	
❒	❒	Thyroid disease	
❒	❒	Kidney disease	
❒	❒	Muscular/skeletal condition	
❒	❒	Seizures	
❒	❒	Fainting spells	
❒	❒	Psychological/emotional difficulties	
❒	❒	Learning disorders (ie, ADHD, ADD)	
❒	❒	Sleep disorders (ie, sleep walking)	
❒	❒	Gastrointestinal problems	
❒	❒	Surgery	
❒	❒	Serious injury	
❒	❒	Other	

MEDICATIONS: List all medications currently used. If additional space is needed, please photocopy and attach this part of the health form. Rescue inhalers and EpiPen information **must** be included, even if they are for occasional or emergency use only.
NOTE: Be sure to bring all medications in appropriate containers and make sure they are NOT expired.

Medication	Medication	Medication
Strength	Strength	Strength
Frequency	Frequency	Frequency
Reason for use	Reason for use	Reason for use
❒ Chronic use ❒ As needed use	❒ Chronic use ❒ As needed use	❒ Chronic use ❒ As needed use
Medication	Medication	Medication
Strength	Strength	Strength
Frequency	Frequency	Frequency
Reason for use	Reason for use	Reason for use
❒ Chronic use ❒ As needed use	❒ Chronic use ❒ As needed use	❒ Chronic use ❒ As needed use

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FORM DUE: July 1st

Staff Name: _____ Birth date: _____/_____/_____

Last First Month Day Year

IMMUNIZATION HISTORY:

Provide the month and year for each immunization.

All starred (★) immunizations are required to be up-to-date.

Please check with your provider to ensure immunizations are current.

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)						
★ Measles, mumps, rubella (MMR)						
★ Polio (IPV)						
★ Hepatitis B						
★ Varicella (chickenpox)						

****MANDATORY****

due to new requirements

Attach copy of immunization record/card below

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IMMUNIZATION EXEMPTION REQUEST

On religious, philosophical, or medical grounds, I request exemption for me and/or my child from all vaccinations and/or immunizations required by LABCC for attendance to Camp Morning Star. I understand that a medical evaluation and screening by a licensed health-care practitioner is necessary to reduce the possibility of exposing other camp participants to a communicable disease. In consideration of these exemptions, I understand that I accept complete responsibility for the health of me and/or my child, and I hereby release and agree to hold harmless LABCC and any of its officers, agents, and representatives from any liability that might arise during activities by virtue of this exemption. Other participants will be notified that not all participants may be up to date with recommended vaccinations. It is further understood that, should an emergency arise, the person listed under my Health History Emergency Contact will be notified. In the event that this contact cannot be located immediately, LABCC authorities may take such temporary measures as they deem necessary.

Last Name, First Name:

Participant Signature or Parent / Legal Guardian (if under 18 years old) Signature:	**Date:**

HEALTH SCREENING FORM
LABCC CAMP MORNING STAR

_____ _____

Arrival Date **Departure Date**

Staff Name: _____

Last First

Health screening of campers and staff is critical to prevent an illness outbreak from starting. Per Title 17, Section 30750 of the California Code of Regulations, screening shall be conducted by a qualified staff member for all campers under the age of 18 who are unaccompanied by a parent or guardian within 24 hours of arrival at camp. It is recommended, pre-screening of campers and staff be done prior to arriving at camp to prevent the spread of illness. Records of health screenings and procedures must be maintained at the camp.

Did you submit of copy of your immunization record? ❒ YES ❒ NO

Have you been exposed to any known contagious disease in the week prior to camp?

No	Yes	If yes, please explain:
❒	❒	

Have you shown any of, or been in contact with others who exhibited, the following symptoms within <u>24 to 48 hours</u> prior to camp arrival?

No	Yes	
❒	❒	Fever (oral temperature 100.4°F or above)
❒	❒	Sore throat with fever
❒	❒	Vomiting
❒	❒	Diarrhea
❒	❒	Severe itching of body or scalp
❒	❒	Open draining sore on skin
❒	❒	Severe headache
❒	❒	Flu or flu-like symptoms (fever, sore throat, cough, weakness, fatigue, sneezing, nausea, body aches)
❒	❒	Rash

Result of health screening (to be filled out by LABCC Health Supervisor)

❒ Attend camp
❒ Quarantine at camp in isolation area
❒ Send home / did not attend camp

_____ _____

Signature of Health Supervisor Date Reviewed