Solid Rock Camp and Retreat Center
Staff Member Health Form

The State of Colorado requires each staff member to have a medical examination (see page 4) by a licensed doctor of medicine (M. D. or D. O.) or nurse practitioner within twenty-four months prior to the camp start date.

According to our records:

___ You do not have a current medical exam on file. Please fill out all 4 pages of this form.

___ You have a current medical exam on file. WE STILL NEED YOU TO FILL OUT THE FIRST THREE PAGES OF THIS FORM. WE NEED CURRENT SIGNATURES.

Your Medical Exam Expires _____

ALONG WITH THIS FORM WE NEED A COPY OF YOUR IMMUNIZATION RECORDS

This form **MUST BE FILLED OUT COMPLETELY** before staff member may begin work at camp.

1. **Staff Member Name**: _____
   Gender: _____ Age: _____ Height: _____ Weight: _____
   Birthday: _____
   Address: _____
   City/State/Zip: _____
   Primary Phone: _____

2. **Parent/Guardian Name** (if under 18): _____
   Cell Phone(s): _____
   Place of Employment: _____
   Business Address: _____
   City/State/Zip: _____
   Business Phone: _____

3. **Doctor's Name**: _____
   Address: _____
   City/State/Zip: _____
   Phone: _____

4. **Dentist's Name**: _____
   Address: _____
   City/State/Zip: _____
   Phone: _____

5. **Emergency Contact**:
   Name: _____
   Address: _____
   City/State/Zip: _____
   Primary Phone: _____ Work Phone: _____

Staff Member Consent to Medical, Dental, or Hospital Care

***Staff members younger than 18 must have parent/legal guardian signature.**

I, _____ am 18 years or older.

(Name of Staff Member – hereinafter "me" or "myself")

I, _____, am the parent or legal guardian of _____
(Name of Parent/Legal Guardian) (Name of Minor-hereinafter "my child")

I consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for me/my child. This authority also extends to any x-ray examination, anesthetic, dental, or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for myself/my child. I further agree to pay all charges for the dental, medical, or hospital care or treatment.

As parent or legal guardian of my child or as an individual who is 18 or older, I am responsible for the health care decisions for myself/my child and am authorized to consent to the services to be rendered. I represent that my consent to, and agreement to pay for the dental, medical, or hospital care or treatment to be rendered to myself/my child is legally sufficient and that no consent from any other person is required by law.

I understand that in the case of an emergency, every effort will be made to contact my emergency contact/a responsible parent or guardian of the staff member. In the event that contact cannot be made, I hereby give permission to the camp administration and the physician they may select to secure proper treatment for, to hospitalize, and to order such injections, anesthesia or operations as may be urgently necessary for me/my child. In the event of a claim, my/our medical insurance (if any) will be liable.

I hereby authorize Solid Rock Camp & Retreat Center's physician to act as the prescriptive authority for myself/my child while I/ he/she is at camp. I understand that the Doctor's standing orders are available for my inspection upon request.

_____ Date: _____, 20_____
Signature of Staff Member or Parent/Legal Guardian of staff member who is younger than 18

_____
Printed name of Staff Member or Parent/Legal/Guardian of staff member who is younger than 18

Activities Statement

Please read and indicate your consent to each item below by initialing the space provided and signing below:

_____ I hereby agree/give my permission for my child, to work at Solid Rock Camp & Retreat Center and to participate in all camp activities. I give permission for me/my child to, participate in any off-site activities during camp and to be transported to and from these activities, including emergency situations (if any) by authorized vehicles. I will not hold Solid Rock Camp & Retreat Center or its agents liable for injury caused by common accident, illness or the rendering of emergency care.

Please note any exceptions to the above here: _____

_____

_____

_____ Date: _____, 20_____
Signature of Staff Member or Parent/Legal Guardian of staff member who is younger than 18

_____
Printed name of Parent/Legal Guardian or staff member who is 18 or older

Health History

Name of Staff Member _____

This section must be filled out by the parent/guardian or the staff member who is 18 years old or older.

1. Does the camper now have, or has the camper been subject to in the past, any of the following? Please check yes or no. If yes, please explain.

	Yes	No	Remarks
AIDS (HIV Virus)	☐	☐	_____
Allergy, food or drug*	☐	☐	_____
Allergy, animals*	☐	☐	_____
Allergy, other*	☐	☐	_____ _____
Appendicitis	☐	☐	_____
Asthma*	☐	☐	_____
Convulsions/Seizures*	☐	☐	_____
Diabetes*	☐	☐	_____
Digestive Problems	☐	☐	_____
Ear Trouble (hearing)	☐	☐	_____
Emotional Disturbances	☐	☐	_____
Epilepsy	☐	☐	_____
Heart Trouble	☐	☐	_____
Hernia	☐	☐	_____
Lung Trouble	☐	☐	_____
Skin Trouble	☐	☐	_____
Surgery within last year	☐	☐	_____

***Please note that if staff member has a history of asthma, diabetes, seizures or severe allergic reaction, complete written instructions are required indicating all medications, treatment, and restrictions.**

2. What communicable diseases has the staff member had? Please check those that the camper has had.

☐ Chicken Pox ☐ Diphtheria ☐ Whooping Cough ☐Polio ☐ Measles ☐ Mumps ☐Scarlet Fever

3. Is staff member presently under treatment for any medical condition? ☐ Yes ☐ No If yes, please explain:

_____

_____

4. Is staff member presently taking any medication? ☐ Yes ☐ No

If yes, please explain: _____

_____

******PLEASE INCLUDE A COMPLETED AND SIGNED MEDICATION AUTHORIZATION FORM FOR EACH MEDICATION (PRESCRIPTION & OVER-THE-COUNTER) BEING ADMINISTERED AT THE TIME OF CAMP (if staff member is younger than 18).******

5. Please describe any physical handicaps, exercise restrictions or special diet needed by the camper or staff member.

_____

_____

MEDICAL EXAMINATION

Name of Staff Member _____

The State of Colorado requires that this section be completed and signed by a licensed doctor of medicine (M. D. or D. O) or nurse practitioner within twenty-four months of the camp date.

1. Health History (page 3) Reviewed: □ Complete and True □ Incomplete
2. Please check the condition of the person being examined in each of the areas listed:

	Normal	Abnormal	Remarks
a. Blood Pressure	□	□	_____
b. Ears	□	□	_____
c. Eyes	□	□	_____
d. Feet	□	□	_____
e. Heart	□	□	_____
f. Lungs	□	□	_____
g. Scalp	□	□	_____
h. Skin	□	□	_____
i. Throat	□	□	_____

3. Tetanus Toxoid: Given: _____ (Date) Needed in case of injury? □ Yes □ No

4. The camper participation in the program can be: □ Full □Limited

If limited, please explain: _____

_____

5. Other comments or remarks: _____

_____

6. I have examined _____ and found him/her free from communicable diseases.

_____ _____

(Signature of M.D., D.O., or Nurse Practitioner) (Date)

Physician's Name: _____

Physician's Address: _____

City/State/Zip: _____

Phone Number: _____

•Please note that a completed and signed Medication Authorization Form <u>is required for EACH medication</u> (prescription & over-the-counter) being administered at the time of camp (if staff member is younger than 18).