



Solid Rock Camp and Retreat Center Staff Member Health Form

Please complete all three pages of this form. The State of Colorado requires that we have this information and the health history on file for every staff member. Items 3, 4, and 5 below are required, as are the signatures on page 2. When you have completed this form, please email the form to manager@soldirockcampco.com, or mail it to Solid Rock Camp, 2728 Lower Twin Rocks Road, Florissant, CO 80816. Address it to the attention of Dick Becker. Thank you.

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.

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

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 me/ 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: _____

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

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)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy, food or drug*	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy, animals*	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergy, other*	<input type="checkbox"/>	<input type="checkbox"/>	_____
Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma*	<input type="checkbox"/>	<input type="checkbox"/>	_____
Convulsions/Seizures*	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes*	<input type="checkbox"/>	<input type="checkbox"/>	_____
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear Trouble (hearing)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emotional Disturbances	<input type="checkbox"/>	<input type="checkbox"/>	_____
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Surgery within last year	<input type="checkbox"/>	<input type="checkbox"/>	_____

***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 staff member.
