Berkshire Hills 2024 STAFF Health Exam Form

Name: _____ DOB: _____/_____/_____ Age at camp: _____

Health Care Recommendations by Licensed Medical Personnel

Examination Date: _____/_____/_____ Weight: _____ Height: _____
In my opinion, this person is able to participate in an active camp program.
This person is under the care of a physician for the following conditions and the physician has the following recommendations and/or restrictions for the camper's time at camp (please include allergies/special diet):
_____
_____

I require an EpiPen: Yes_____ **No** _____ (Please bring **TWO** EpiPens to camp)
EpiPen Name: _____

*****Date of last TETANUS shot ____/____/____ (must be within 10 years)*****

MEDICATION: My physician and I give camp permission to administer all of the following medications in generic or brand form as available based on the dosage, schedule, and for the indications per medication label instructions. **ANY MEDICATION TAKEN DAILY MUST BE ORDERED THROUGH OUR MEDICATION SERVICE** which packages medicines into individual doses.

Over The Counter (OTC) Medications: *These are stocked by camp in case of illness.*
****PLEASE CROSS OUT ANY OTCs YOU DO NOT WANT CAMP TO PROVIDE****

Dramamine	Acetaminophen	Zyrtec	Allegra	Sudafed	Mylanta	MiraLax	Throat Lozenges
Bonine	Ibuprofen	Claritin	Benadryl	Robitussin	Pepto Bismol	Tums	Aloe Vera

Please list ANY OTHER MEDICATION to be taken by you. All DAILY medications in pill form must be ordered through our medication service. **WE CANNOT GIVE ANY MEDICATION NOT LISTED ABOVE OR BELOW**

*Rx Medications	Dosage/Schedule	OTCs (taken DAILY only)	Dosage/Schedule

>>> SIGNATURE OF LICENSED PHYSICIAN: _____
Printed Name: _____ Date: ____/____/____ Phone: _____
Address: _____

This health history is correct and accurately reflects my health status, and I give permission to administer all medications listed above. The staff member has permission to participate in all camp activities except as noted by me and /or an examining physician. I give permission to the physician selected by camp to order x-rays, routine tests, and treatment related to my health for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give permission to the physician to hospitalize, secure proper treatment for, and order injections, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with camp staff. I give permission to photocopy this form. In addition, the camp has permission to obtain a copy of my health record from providers who treat me, and these providers may talk with the program's staff about my health status.

>>> STAFF SIGNATURE: _____ Print Name: _____

>>> PARENT SIGNATURE OF UNDER 18 STAFF: _____ Print Name : _____