

**POCONO PLATEAU CAMP & RETREAT CENTER**

304 Pocono Plateau Rd.  
CRESCO, PA 18326

Phone: 570-676-3665  
Fax: 570-676-9388

**Volunteer Staff Health History Form**

Camp No(s) \_\_\_\_\_  
\_\_\_\_\_

**PERSONAL INFORMATION:**

Please bring this form with you to camp!

Name \_\_\_\_\_ SS# \_\_\_\_\_

Home Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Email Address \_\_\_\_\_

Spouse or Parent/Guardian \_\_\_\_\_ Relationship \_\_\_\_\_

Address (if different from above) \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_) \_\_\_\_\_

**Emergency Contacts** In case of an emergency, please notify (indicate by number the order of preference -1, 2, 3)

(\_\_\_\_) Spouse or Parent/Guardian Above

(\_\_\_\_) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_) \_\_\_\_\_

(\_\_\_\_) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone: Day (\_\_\_\_) \_\_\_\_\_ Evening (\_\_\_\_) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Dentist/Orthodontist Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

**INSURANCE INFORMATION:** Insurance information is required since staff are covered by limited accident or medical insurance – in excess of the patient's insurance. Camp's policy is only a secondary policy. PA law prohibits duplicate payments.

Are you covered by medical/hospitalization insurance? **NO** If YES, please indicate carrier or plan name and complete below: \_\_\_\_\_

(i.e., Blue Cross)

Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Policy Holder SS# \_\_\_\_\_

**MEDICAL INFORMATION:**

Height \_\_\_\_\_ Weight \_\_\_\_\_ **DATE OF LAST TETANUS (DTP, DT,TT) (Month/ Year):** \_\_\_\_\_

Are all immunizations up to date?  Yes  No

**ILLNESSES AND INJURIES** (Check those that apply)

- |                                       |   |  |
|---------------------------------------|---|--|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Bleeding/Clotting Disorder   | <input type="checkbox"/> Convulsions/Seizures  |
| <input type="checkbox"/> Diabetes     | <input type="checkbox"/> Sickle Cell Disease          | <input type="checkbox"/> Hypertension          |
| <input type="checkbox"/> HIV          | <input type="checkbox"/> Heart Disease/Defect         | <input type="checkbox"/> Kidney Disease        |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Upper Respiratory Infections | <input type="checkbox"/> Other (Specify) _____ |

DATE OF LAST HEALTH EXAM \_\_\_\_\_ Were any problems noted at that time? \_\_\_\_\_

Are you currently under a physician's care for a medical problem? **Y N** Explain: \_\_\_\_\_

\_\_\_\_\_

Since your last health exam, have you had:

\_\_\_ A serious injury requiring medical attention? Date: \_\_\_\_\_ Explain? \_\_\_\_\_

\_\_\_ A surgical operation or fracture? Date: \_\_\_\_\_ Explain? \_\_\_\_\_

\_\_\_ A diagnosed infectious/communicable disease? Date: \_\_\_\_\_ Disease: \_\_\_\_\_

\_\_\_ Medication prescribed by a physician to be taken on a regular basis? Date: \_\_\_\_\_ Explain? \_\_\_\_\_

\_\_\_ A physician's restriction from participating in any physical activity? \_\_\_\_\_

**ALLERGIES** (Check those that apply)

\_\_\_ Animals                      \_\_\_ Foods                      \_\_\_ Insect Stings                      \_\_\_ Seasonal/Environmental  
\_\_\_ Medications                      \_\_\_ Plants (Poison Ivy, etc)                      \_\_\_ Other (Specify) \_\_\_\_\_

Please explain any allergies checked above and list treatment if any is necessary. \_\_\_\_\_

**OTHER HEALTH CONDITIONS** (Check those that apply)

\_\_\_ Fainting                      \_\_\_ Hearing Impairment                      \_\_\_ Nosebleeds  
\_\_\_ Sleepwalking                      \_\_\_ Wears Glasses/Contacts                      \_\_\_ Special Dietary Regimen

Please explain any of above checked items or other conditions not mentioned. \_\_\_\_\_

**Medications** ***ALL** medications are to be checked in to the Health Supervisor upon arrival at camp. For these purposes, "medications" include those that are prescription, non-prescription, over-the-counter (i.e. Tylenol, cough syrup), home remedies, and vitamins. We ask your fullest cooperation in this matter so that the health and well being of all campers and staff may be properly safeguarded.*

- Check one:  I will take **No medication** at camp.  
 I will take **medication** at camp and will check in **each** of my medications with the Health Supervisor upon arrival. The Health Supervisor and I will then determine where my medications can best be locked in storage to comply with the standards of the camp.

**Certification and Authorization**

By my signature below I, your full name, certify and agree to the following:

- ❖ I certify that the information provided on this Health History and Examination Form is, to the best of my knowledge, complete and accurate. I/my child will engage in all camp activities except as noted. This completed form may be photocopied for trips out of camp. I understand the requirement that all staff be screened by the camp Health Supervisor upon arrival, and I give my permission for the conduct of such an examination.
- ❖ During the dates of participation (noted above), I/my child will fully participate in the activities associated with the summer camping program of Pocono Plateau Camp & Retreat Center of the Eastern PA Conference - United Methodist Church. These activities may include, but are not limited to, the following: camping outdoors, sports, games, low ropes, high ropes, zip line, climbing tower, rock climbing, archery, caving, boating/canoeing, swimming, etc., either off- or on-site as per the prescribed camp event(s). I understand that there are inherent and other risks associated with these activities. I hereby do indemnify and hold harmless Pocono Plateau Camp & Retreat Center, the Eastern Pennsylvania Conference – United Methodist Church, and their directors, officers, employees, staffs, and volunteers in the event of injury or damages and if legal action is brought on account of those injuries or damages.
- ❖ **FOR JR. & SR. HIGH PROGRAMS:** I authorize the Director of Pocono Plateau Camp & Retreat Center or his designee to sign on my behalf any release/waiver forms required by facilities (i.e., climbing gym, outfitter, etc.) that I/my child might need as a part of the prescribed camp program.
- ❖ In the event of an emergency if I am unable to make decisions and my emergency contacts (named above) can not be contacted, the Director of Pocono Plateau Camp & Retreat Center or his designee is authorized to act on my behalf to care for me/my child in securing medical treatment including hospitalization, ordering x-rays and routine tests. I give permission to the camp to arrange necessary related transportation. I agree to the release of any records necessary for insurance.
- ❖ I agree that in case of my/my child's injury, I/my child may be required to depart from Pocono Plateau and its programs, whether on- or off-site (trip/travel camps). The Plateau's goal is to limit the inconvenience and discomfort of campers and other staff if the situation arises where a staff member has an issue that cannot be quickly resolved.

My Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Parent/guardian: \_\_\_\_\_ Date \_\_\_\_\_  
(if volunteer is under age 18)