PHOEBE NEEDLES CENTER, INC.

STAFF MEDICAL INFORMATION FORM

This form should be completed by a parent or guardian for any staff member under the age of 18.

STAFF'S NAME _____
(first) (middle) (last) (preferred)

Date of Birth _____ Gender _____

Parent/Guardian's Name _____

Address _____

City, State, Zip Code _____

Primary Phone Number _____ Secondary Phone Number _____

In case of emergency, contact _____ Relationship _____

Primary Phone Number _____ Secondary Phone Number _____

What is the current status of your/your youth's health? _____

Name of your/your youth's physician or clinic _____ Phone number _____

Do you/your youth have health insurance coverage? yes _____ no _____

Name of company _____ Group/Individual Policy Number _____

Identification Number _____ Phone Number _____

Address _____

Are you/Is your youth allergic to bee or wasp stings? yes _____ no _____ If so, will you/they have medication with them? _____

List any activities from which you/your youth should be restricted _____

List any dietary restrictions _____

COVID-19 VIRUS GUIDELINES

☐ Check this box if you/your youth has received the COVID-19 vaccine.

Date of 1st Dose _____ Date of 2nd Dose _____
Type of 1st Dose _____ Type of 2nd Dose _____

The American Academy of Pediatrics (AAP) has recommended that everyone over 16 years of age should receive the COVID-19 vaccine. Phoebe Needles Center, Inc. **IS NOT** excluding campers or staff who have not received the COVID-19 vaccine.

The recommendation of PNCI, the AAP, and the Centers for Disease Control (CDC) is that individuals wear a face covering when not able to maintain a physical distance of 6 feet and wash hands frequently, even after being vaccinated. If your camper has received the vaccination for COVID-19, please attach a copy of your vaccination certificate. ***This policy is subject to change as updated information becomes available.***

FOR OFFICE USE ONLY (to be completed by medical screener)

Check Medications _____ *Check Allergies* _____ *Check Restrictions* _____ *COVID-19 Screening* _____

STAFF'S NAME _____

GENERAL HEALTH QUESTIONS

Has/does you/your youth:
(If yes, please explain on the back of page 3)

1. Had a recent injury, illness, or infectious disease?	Yes	No
2. Have a chronic or reoccurring disease?	Yes	No
3. Have frequent headaches?	Yes	No
4. Wear glasses, contacts, or protective eyewear?	Yes	No
5. Have ear/sinus problems?	Yes	No
6. Ever had frequent infections?	Yes	No
7. Ever passed out during or after exercise?	Yes	No
8. Ever been dizzy during or after exercise?	Yes	No
9. Ever had seizures?	Yes	No
10. Ever had low or high blood pressure?	Yes	No
11. Ever been diagnosed with a heart murmur?	Yes	No
12. Ever have heart disease (CHF, CAD, MI)?	Yes	No
13. Have COPD?	Yes	No
14. Ever have a Stroke/TIA?	Yes	No
15. Ever had back problems?	Yes	No
16. Ever have joint problems (knees, ankles)?	Yes	No
17. Require an orthodontic appliance?	Yes	No
18. Have skin problems (rash, acne, itching)?	Yes	No
19. Have diabetes?	Yes	No
20. Have asthma?	Yes	No
21. Have constipation or diarrhea?	Yes	No
22. Sleepwalk?	Yes	No
23. Sleep disorders? (including bedwetting)	Yes	No
24. Have an abnormal menstrual history?	Yes	No
25. Have an eating disorder?	Yes	No
26. GI problems (Abdominal, digestive)?	Yes	No
27. Have emotional/mental/behavioral difficulties that required professional help?	Yes	No
28. Have ADD or ADHD?	Yes	No
29. Use any type of tobacco products?	Yes	No
30. Had any recent surgery (last year)?	Yes	No

ALLERGIES

List any known allergies, or state "NONE" to:

MEDICATIONS: _____

_____

Reactions: _____

Treatment: _____

FOODS: _____

_____

Reactions: _____

Treatment: _____

PLANTS, ANIMALS, ETC.: _____

_____

Reactions: _____

Treatment: _____

OTHER: _____

_____

Reactions: _____

Treatment: _____

☐ Check this box to give PNCI staff permission to apply sunscreen to you/your youth if you/they need assistance.

Is there any other information you think we should know about you/your youth? _____

_____

VERIFICATION OF IMMUNIZATIONS

I, _____ (custodial parent/legal guardian), attest that, _____ (staff), has received

ALL immunizations required for public schools in Virginia, and that these immunizations are up to date as of June 1, 2023: required for public schools in Virginia, and that these immunizations are up to date as of June 1, 2023: Diphtheria, Tetanus, & Pertussis (DTaP, DTP, or Tdap); Haemophilus Influenzae Type b (Hib) Vaccine; Hepatitis B Vaccine; Human Papillomavirus Vaccine (HPV); Measles, Mumps, & Rubella (MMR) Vaccine; Pneumococcal (PCV) Vaccine; Polio Vaccine; Varicella (Chickenpox) Vaccine.

The date of my/my youth's most recent tetanus shot is _____ (month/year).

STAFF'S NAME _____

MEDICATIONS

All medications (prescription and non-prescription) must be brought to camp IN THE ORIGINAL CONTAINER/PACKAGING, identifying physician (if prescription), name of medication, dosage and frequency of administration. Bring enough medication to last the entire session of camp. Attach additional pages if needed to list all medications. IF NO MEDICATIONS ARE BEING USED, STATE "NONE."

NAME OF MEDICATION _____

Dosage : _____

Frequency: _____

Reason for Taking: _____

NAME OF MEDICATION _____

Dosage : _____

Frequency: _____

Reason for Taking: _____

NAME OF MEDICATION _____

Dosage : _____

Frequency: _____

Reason for Taking: _____

NAME OF MEDICATION _____

Dosage : _____

Frequency: _____

Reason for Taking: _____

SELF OR PARENT'S AUTHORIZATION FOR MEDICAL TREATMENT

The information on this form is correct and complete so far as I know, and the person herein described has permission to engage in all prescribed Summer Camp @ Phoebe Needles activities, except as noted by me.

I understand that there is a certain degree of risk and possible injury in regard to the nature of the program and its activities. I hereby give my permission to the staff of Phoebe Needles Center, Inc. to provide routine health care, administer prescribed medications and seek emergency medical treatment, including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give my permission to Phoebe Needles Center, Inc. to arrange necessary related transportation for me/my youth. In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by Phoebe Needles Center, Inc. to secure and administer treatment, including hospitalization, for the above named person. This completed form may be photocopied for trips off Phoebe Needles Center, Inc. property.

During the time you/your youth is employed at Phoebe Needles Center, Inc., you/they will be provided with secondary insurance coverage for medical expenses due to accident or illness. This includes activities on and off Phoebe Needles Center, Inc. property.

_____

Self or Parent/Guardian Signature
(if staff member is under 18 years old)

Print Name _____

Relationship _____

Date _____

USE OF OVER-THE-COUNTER MEDICATIONS

Circle "yes" or "no" to any over-the-counter medications you/your youth may or may not receive if needed while employed at Phoebe Needles Center, Inc.

Acetaminophen or Tylenol (pain)	Yes	No
Pepto Bismol or generic (upset stomach)	Yes	No
Cough Suppressant plain (cough)	Yes	No
Benedryl pills or generic (itching or rash)	Yes	No
Ibuprofen or Advil (inflammation)	Yes	No
Antacid Tablets	Yes	No
Anti-diarrheal (diarrhea)	Yes	No
Calamine Lotion or Cortaid (itching or rash)	Yes	No
Hydrocortisone 1% Cream (itching)	Yes	No

PLEASE RETURN ALL MATERIALS TO:

The Phoebe Needles Center, Inc.
732 Turners Creek Road
Callaway, Virginia 24067-5814
(540) 483-1518
Fax (540) 483-2235 | PNCenter@gmail.com
Additional forms available at www.PhoebeNeedles.org