Camp Bethel Staff/Volunteer Health Form 2021 for Adults age 18 and over revised 05.14.2021

You may complete this form online at www.CampBethelVirginia.org/StaffResources. The following information must be filled in by the adult staff member. Information from this form will be held confidential by the directors and medical director. The intent of this form is to provide the Health Coordinator with information needed to provide appropriate emergency care. Keep a copy of this completed form for your records. Attach additional pages or descriptions as needed. Provide changes to this form to the camp director if needed. Please PRINT. ***If you have insurance, please attach or upload a copy/scan of your individual OR family medical insurance card.***

FIRST name _____ LAST name _____ Birth Date_____

Permanent address (where we will mail your W2s) _____

City_____ State_____ Zip_____

Your cell phone_____ Your home phone_____

Your email address_____

Emergency Contact Information: *First & Last Name* _____

Their main phone _____ *include area code, (ex: 540-555-1234)*

Other contact in emergency_____

Their main phone _____ *include area code, (ex: 540-555-1234)*

INSURANCE INFORMATION: If you have insurance, either upload a scan/image of the front & back of your insurance card using the upload portal at https://www.campbethelvirginia.org/staffresources.html OR attach a photocopy or image of the front & back of your medical insurance card and return it with this form. Contact our office for exceptions.

Are you covered by family medical/hospital insurance? ____Yes. ____No. Are you covered by Medicaid? ____Yes. ____No.

Primary Care Physician: _____; Phone: (_____)_____

Hospital affiliation: _____

ALLERGIES & RESTRICTIONS: List all known allergies and restrictions. Describe the severity of each including your reaction and the best management of the reaction. Describe the best accommodation, adaptations, or limitations of any restrictions. Attach additional paper if needed or send to CampBethelOffice@gmail.com. If none, leave blank or write NONE.

Food allergies _____

Medication allergies _____

Other or environmental allergies _____

Dietary restrictions_____

Restrictions or exemptions to camp activities _____

Other restrictions or health concerns _____

MEDICAL HISTORY: Describe any injury, illness, medical treatment, or surgery the camp should know in case of emergency.

_____

ADDITIONAL INFORMATION: Describe other physical, emotional, or behavioral concerns, or any conditions requiring medication, treatment, or special restrictions or considerations while at camp.

_____

_____

MEDICATION NECESSARY DURING CAMP EMPLOYMENT: List ALL medications (including non-prescription drugs) on the Medication Form. Bring enough medication to last the entire time at camp. Keep it in the original packaging naming prescribing physician, name of medication, dosage, and frequency of administration. If, during your employment at Camp Bethel, you will be taking medication that might impair your ability to perform essential functions described in your position description, call today to speak with the Camp Director or Health Coordinator.

___ I take NO medications on a routine basis.

___ YES, I take routine medication, and I will complete the Medication Instructions form on page 3.

COVID-19 VACCINATION STATUS: ☐ Fully Vaccinated*, ☐ Partially Vaccinated*, ☐ Not Vaccinated

*If fully or partially vaccinated, you must submit a legible image/scan of your Vaccination Record Card to us via email at CampBethelOffice@gmail.com, or by using our Uploads portal at www.CampBethelVirginia.org/StaffResources.

The following box must be signed. If for religious reasons you cannot sign, contact the camp for legal waivers that must be signed for camp attendance. If you have insurance, attach a photocopy or scan of the front and back of your medical insurance card and return it with this form.

Authorization by Individual (for adult staff & volunteers):

I hereby request that I be accepted to attend Camp Bethel. I have read and understand the 2021 Summer Staff Information packet, the Record of Agreement packet, and the summer camp brochure, including staff policies, the camp rules and behavior policies, position descriptions, the program descriptions and the activities listed for my service at camp. I understand that I will be participating in many physical activities (including, but not limited to those listed in the program descriptions and Staff Information) and the potential for accidents exists. I understand that the camp has established guidelines to minimize risks and provide a safe environment, and that Camp Bethel will implement multiple practices to limit the spread of and exposure to communicable diseases (including COVID-19 and other viruses), and that Camp Bethel is licensed by Virginia to operate a Summer Camp, Dining Hall and Swimming Pool, and that Camp Bethel adheres to over 300 operational and safety standards. In consideration of acceptance to Camp Bethel,

- I indemnify and hold harmless Camp Bethel, the Virlina District Board–Church of the Brethren, Inc. and its staff and officers from all liability, claims, damage, injury or illness sustained, and
- I verify that the information on this Health Form is correct and complete as far as I know. This form may be copied for camp records, and
- I hereby give permission to the camp to provide routine health care and seek emergency medical treatment. I agree to the release of any records necessary for emergency purposes. I give permission to the camp to arrange necessary emergency medical transportation. I hereby give permission to the physician selected by the camp to secure and administer treatment including ordering x-rays, administering tests, and admittance to a hospital, and
- I understand that Camp Bethel provides Workers Insurance and limited secondary medical insurance coverage for participants. I will attach proof of personal/family medical insurance coverage, and
- I understand the active nature of the camp activities and I agree to participate fully and to engage in all camp activities including archery, the group challenge & initiatives course, the high ropes course and climbing wall, unless otherwise noted under restrictions on this form. I understand that climbing at any height, using climbing equipment (climbing wall/high ropes course) and archery activities may have inherent risks and that participation may involve accidents that could result in injury. I understand that climbing wall, high ropes and archery activities are "challenge by choice" and that I will not be forced to participate, and
- Should it become necessary to leave site or return to my home because of illness, injury or other reason, I will accept the Director's decision and arrange for transportation, and
- I understand that my service at Camp Bethel includes transportation ON SITE, and I agree to be transported on site in camp-approved vehicles driven by camp-approved drivers, and
- I understand that my service at Camp Bethel likely includes transportation OFF SITE (adventures, trips, service projects), and I agree to leave the grounds of Camp Bethel accompanied by authorized camp personnel for approved out-of-camp activities at camp-approved locations, to be transported in camp-approved vehicles driven by camp-approved drivers, and
- I agree to read all information included in continuing communications, letters and e-mails, and to read, sign and return any and all applicable forms including this Health Form, and
- I permit camp photos, video and audio of activities or interviews that include me to be used in camp promotion without liability or remuneration, and
- I verify that the information on this Health Form is correct and complete as far as I know, and
- I verify the Physical Assessment of the above named as described below.

Physical Assessment by Individual or medical personnel: *We encourage you to consult your primary care physician to assess your current health and physical abilities. Provide any updates or changes to this information to the Camp Director if needed.* **I am physically able to participate in all camp activities (unless otherwise noted under Restrictions/Exemptions above), and I will provide an update to the health status and Health Form, if any.**

***Signature of adult staff/volunteer:** _____ *Date: _____

***Printed name of who signed this form:**_____ ***Phone number:**_____

CAMP BETHEL ADULT MEDICATION FORM (*Complete ONLY if you will bring medication to camp.*)

If you will be bringing any medication to take during your time at camp, YOU MUST RECORD precise instructions here and return this form to Camp Bethel. All medications must be verified by our Health Coordinator. All medications are stored in NON-camper staff quarters unless special arrangements are made through the Health Coordinator and Camp Director. Medications MUST be in the original, prescribed and labeled container with your name, medication name & strength, and dosage instructions. Only bring enough medication for your time at camp.

Staff's FIRST name _____ Staff's LAST name _____

LIST ALL MEDICATIONS: List names of medications (including non-prescription) and the reasons for taking.

_____

_____

_____

SCHEDULE OF DOSAGES: In the chart below, list the name of each specific medication. Under each medication, list the dose to administer beside each day and specific time administered. *See the "Example Column."* Please try to coordinate medication times with meal times and bed time, since it is difficult to keep up with odd schedules. You must initial each time the dosage has been dispensed. If medication must be dispensed at a different time, please note. The times listed in the chart mostly correspond to meals: 8:00am breakfast, 12:30pm lunch, 5:30pm dinner; and bedtime 9:30pm.

		Medication #1		Medication #2		Medication #3		Medication #4		***"Example Column"***	
Write medication names here ==>										***Penicillin:*** *1 tablet twice daily at breakfast and bedtime*	
		Dose to give each time	Health Coord initials	Dose to give each time	Health Coord initials	Dose to give each time	Health Coord initials	Dose to give each time	Health Coord initials	Dose to give each time	Health Coord initials
Sunday	**5:30 pm**										
	9:30 pm									*1 tablet*	
Monday	**8:00 am**									*1 tablet*	
	12:30 pm										
	5:30 pm										
	9:30 pm									*1 tablet*	
Tuesday	**8:00 am**									*1 tablet*	
	12:30 pm										
	5:30 pm										
	9:30 pm									*1 tablet*	
Wednesday	**8:00 am**									*1 tablet*	
	12:30 pm										
	5:30 pm										
	9:30 pm									*1 tablet*	
Thursday	**8:00 am**									*1 tablet*	
	12:30 pm										
	5:30 pm										
	9:30 pm									*1 tablet*	
Friday	**8:00 am**									*1 tablet*	
	12:30 pm										
	5:30 pm										

MEDICATION AS NEEDED: List meds you will have in your possession for use only if needed AND a description of the condition for which you feel they should be administered plus the dosage.

_____

_____