Registrar Office:
6 Soundview Drive North
Huntington, NY 11743
(631) 351-1657

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Email: info@mahetu.org

ACA Accredited

Employee Health History Form 1

(To be completed by Employee or Parent/Guardian if under 18 years of age)

Employee Information:

Employee Name: _____
(Last Name) (First Name) (Middle Initial)

Address: _____ _____ _____ _____
(Street) (City/Town) (State) (Zip Code)

Date of Birth: _____ Age: _____ Gender: _____
(MM/DD/YY)

Emergency Contact:

Name: _____ Relationship: _____
(Last Name) (First Name)

Address: _____ _____

Phone: _____ Cell: _____ Email: _____

If under 18 years if age: Parent(s)/Guardian(s) with legal custody:

(1)Name: _____ Relationship: _____
(Last Name) (First Name)

Phone: _____ Cell: _____ Email: _____

(2)Name: _____ Relationship: _____
(Last Name) (First Name)

Phone: _____ Cell: _____ Email: _____

Employee's Health Care Providers

(1) Pediatrician/Primary Care Provider:
Name: _____ Phone: _____

(2) Dentist
Name: _____ Phone: _____

(3) Orthodontist
Name: _____ Phone: _____

Medical Insurance Information

The employee is covered by medical/hospital insurance: ☐ Yes ☐ No

Include a copy *of insurance card; copy* ***both sides*** *of the card so information is legible*

Insurance Company: _____ Grp/Policy#: _____

Subscriber: _____ Ins. Co Phone #: _____

Employee Health History Form 1 (To be completed by Employee or Parent/Guardian)	Employee Name:	(Last Name)	(First Name)	(Middle Initial)	Date of Birth:	(MM/DD/YY)

General Health History:

Check "Yes" or "No for each statement. Explain "Yes" answers below.

Has/does the employee:

1. Ever been hospitalized/had surgery? ☐ Yes ☐ No
2. Have recurrent/chronic Illnesses? ☐ Yes ☐ No
3. Had a recent infectious disease? ☐ Yes ☐ No
4. Had a recent injury? ☐ Yes ☐ No
5. Had asthma/wheezing/ shortness of breath? ☐ Yes ☐ No
6. Have diabetes? ☐ Yes ☐ No
7. Had epilepsy/seizures? ☐ Yes ☐ No
8. Had headaches/migraines? ☐ Yes ☐ No
9. Wear glasses, contacts, or protective eyewear? ☐ Yes ☐ No
10. Had fainting/dizziness/vertigo? ☐ Yes ☐ No
11. Has ever had a concussion? ☐ Yes ☐ No
12. Passed out/chest pain during exercise? ☐ Yes ☐ No
13. Had back/joint problems? ☐ Yes ☐ No
14. Had history of fractures/sprains? ☐ Yes ☐ No
15. Had mononucleosis/mono during the past 12 months? ☐ Yes ☐ No
16. If female, have problems with periods/menstruation? ☐ Yes ☐ No
17. Have problems with falling asleep/sleepwalking? ☐ Yes ☐ No
18. Have history of bedwetting? ☐ Yes ☐ No
19. Have problems with diarrhea/constipation? ☐ Yes ☐ No
20. Had skin sensitivities/eczema/psoriasis? ☐ Yes ☐ No
21. Traveled outside the country in the past 9 months? ☐ Yes ☐ No

Please explain the "Yes" answers on the space below. For travel outside the country, please name the countries visited and dates of travel:

Mental, Emotional, and Social Health:

Check "Yes" or "No for each statement. Explain "Yes" answers below.

Has the employee:

1. Ever been treated for Attention Deficit Disorder (ADD)/Attention Deficit/Hyperactivity Disorder (ADHD)? ☐ Yes ☐ No
2. Ever been treated for Anxiety, depression, Bipolar disorder, or emotional or behavioral difficulties? ☐ Yes ☐ No
3. Ever been treated for an eating disorder? ☐ Yes ☐ No
4. During the past 12 months, seen a professional to address mental/emotional health concerns? ☐ Yes ☐ No
5. Had a significant life event that continues to affect the camper's life? ☐ Yes ☐ No
   (History of abuse, death of a loved one, family change, adoption, foster care, new sibling, survived a disaster, others)

Please explain the "Yes" answers on the space below

Employee Health History Form 1 (To be completed by Employee or Parent/Guardian)	Employee Name:	(Last Name)	(First Name)	(Middle Initial)	Date of Birth:	(MM/DD/YY)

What Have We Forgotten to Ask?

Please provide in the space below any additional information about the employee's health that you think important or that may affect the employee's ability to fully participate in the camp program.

Restrictions:

- ☐ I have reviewed the program and activities of the camp and feel I/the employee can participate in camp activities without restrictions.
- ☐ I have reviewed the program and activities of the camp and feel I/the employee can participate in camp activities with the following restrictions. (Please Specify):

Immunization Attestation

The date of the employee's last tetanus shot was: _____
(Month/Year)

I hereby attest that all immunizations required for school are up to date

_____ _____
Employee Signature (Month/Day/Year)

_____ _____ _____
Parent/Guardian Signature (Required if under 18 years of age) (Month/Day/Year) Relationship

Authorization for Health Care:

This health history is correct and accurately reflects the health status of the person to whom it pertains. The person described 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 the camp to order x-rays, routine tests, and treatment related to my health for both routine health care and in emergency situations. 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.

Additional Authorization for Employees under 18 years of age to be signed by Parent/Guardian:
If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for my child.

_____ _____
Employee Signature (Month/Day/Year)

_____ _____ _____
Parent/Guardian Signature (required if under 18 years of age) (Month/Day/Year) Relationship