CREATIVE SUMMER COUNSELOR HEALTH FORM

COUNSELORS – OVER 18

Holton-Arms School 7303 River Road Bethesda, MD 20817 301-365-6003

ALL ENCLOSED FORMS ARE AVAILABLE ONLINE WWW.HOLTONCREATIVESUMMER.ORG

Health Information – **If any areas do not pertain, please write N/A. No fields may be left blank.**

Counselor Name: _____ Birth Date: _____

Emergency Contact _____ Daytime Phone: _____

Physician Name: _____ Phone Number: _____

HEALTH INFORMATION

Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware: ❑ NO ❑ YES

If YES, please explain:

Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware? ❑ NO ❑ YES

If YES, please explain:

Date of Last Tetanus Shot (Month/Year):

IMMUNIZATION INFORMATION – MUST COMPLETED

State/territory in which Counselor/CIT resides:

For staff members/volunteers who currently reside **within** the United States, a United States territory, or the District of Columbia: Are you **exempt** from any Immunizations? ❑ NO

❑ YES, List _____ If yes, attach ***MDH-896***:

For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia: Attach record of vaccination or immunity on Department form ***MDH-896.***

PRESCRIPTION MEDICATIONS / EPIPENS – Submit Medication Administration Authorization – ***contact the Creative Summer office for a copy of this form.***

APPROVAL FOR OVER-THE-COUNTER MEDICATIONS – Submit Over the Counter Medication Authorization – ***contact the Creative Summer office for a copy of this form.***

In case of emergency and/or when neither parent nor emergency contact can be reached by telephone, I give the Camp Director or, in his/her absence, to a designee, permission to arrange transport to a hospital emergency room for EMERGENCY TREATMENT of illness or injury, and legal authority to consent to such emergency medical treatment for this individual.

I give the Camp Nurse and/or Camp Director permission to contact the counselor's medical providers to exchange pertinent health information as allowed by HIPAA.

_____ _____

Signature of Counselor Date

Revised 1/2020