Trillium Childhood Cancer Support Centre

Returning Staff / Volunteer Health Record

(In effect for **one year** after completion)

Summer site: ____ Year round: ____
Position: ____
Session/Term: ____

Name: ______________________________

Changes to Previous Form? ☐ Yes ☐ No *(If yes, please indicate below)*

Address: ______________________________
Phone Number (Home or Cell): ______________________________
Email: ______________________________
Family Physician: ______________________________
Emergency Contact: ______________________________
Health Card Number ***with*** Version Code: ______________________________

Allergies: *please indicate if you have any of the following allergies.*

Allergy	Yes	No	Not Known	Anaphylactic	If yes, please describe your reaction and the treatment required
Bee Stings					
Food					
Medication					
Seasonal					
Other:					

Nutrition: *our expectation is that staff and volunteers set a good example for campers by eating the provided menu. The kitchen staff will work with some medically prescribed diets but is unable to cater to individual preferences. Due to many peanut and nut allergies at camp, we are diligent to keep peanuts and nuts products out of camp, and ask staff, volunteers and campers to do the same.*

☐ I eat a regular, varied diet
☐ I am a vegetarian:
☐ Semi-vegetarian (no beef or pork)
☐ Pesco (no beef, pork or chicken)
☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
☐ Vegan (no meats, eggs or dairy)
☐ I am lactose intolerant *(please bring your regular management products such as Lactaid)*
☐ Other ______________________________

General Physical/Occupational Health History:

1. Have you been hospitalized in the last 5 years? ____ ☐ Yes ☐ No
2. Do you wear glasses or contacts or use protective eye wear? ____ ☐ Yes ☐ No
3. Have you had any injuries that could affect your job performance? ____ ☐ Yes ☐ No
   If so, where and how does it affect your job?
   ____
4. Do you smoke and/or use other tobacco products? ____ ☐ Yes ☐ No
5. Do you have any piercings? ____ ☐ Yes ☐ No
   If so, where? ______________________________
6. Have you been outside of Canada in the past 9 months? ____ ☐ Yes ☐ No
   If so, where, when and how long? ______________________________
7. Have you ever been told you have an Antibiotic Resistant Organism (ARO) ____ ☐ Yes ☐ No
8. Have you had any significant changes to your health status (i.e seizures, heart issues)? ____ ☐ Yes ☐ No

Please provide details here for questions answered yes:
____
____

Name: ____ **Date of Birth:** ___________________

TB Questionnaire

Question:	Yes:	No:
Have you ever had a POSITIVE TB test?		
Have you been exposed to someone diagnosed with TB?		
Have you ever been told you have TB?		
Have you ever had the BCG vaccine?		
In the past year have you had any of the following symptoms that persisted for greater than 6 months?	**Yes:**	**No:**
Persistent Cough		
Persistent Fever		
Loss of Appetite		
Night Sweats		
Chest Pains		
Coughing up Blood		
Shortness of Breath		
Unexplained Weight Loss		
Weakness or Fatigue		
List the countries that you've travelled to in the last 2 years:		

This health record is complete and accurate insofar as I know. I am capable of performing the essential functions of my job and participating in assigned activities except as noted on the form. I understand that the information on this health record form will be used by the Body Shop (Health Care) staff, in providing care to me and may be shared with your Director of Program. It is my responsibility to update any health related information as it changes.

Signature: ____ Date: ___________________

Parent Signature: ____________________________________ Date: ___________________

(Needed only for staff under age of 18 years)