Trillium Childhood Cancer Support Centre

Staff/Volunteer Health Record 2018

Please Print (*in effect for 2018*)

Name: ____
(*last*) (*first*) (*middle*)

Birth Date: ____________________ (*mm/dd/yyyy*) **Sex**: ❑ Male ❑ Female ❑ Other: ____________________

Home Address: ____
(*street add.*) (*apt./unit*) (*city*) (*province*) (*postal code*)

Telephone: (_____) __________________ **Email**: ________________________________

School Address: ____
(*street add.*) (*apt./unit*) (*city*) (*province*) (*postal code*)

Telephone: (_____)__________________ **Email**: ________________________________

Language: ❑ English ❑ French ❑ Other: ___________________________________

Emergency Contact: *who do you want us to contact in the case of an emergency?*

First contact: __________________________________ Relationship to you: _____________________________

Telephone: (H) (_____) ______________ (W) (_____) ________________ Other (_____) ________________

Alternate contact: ______________________________ Relationship to you: _______ ______________________

Telephone: (H) (_____) ______________ (W) (_____) ________________ Other (_____) ________________

Family Physician: ____ Telephone (_____) __________

Other Health Professionals / Specialists involved with your care

Name ______________________________Specialty ____________________ Telephone (_____) ___________

Name ______________________________Specialty ____________________ Telephone (_____) ___________

Health Card #: __________________________________version code ________ Province: ON ❑ QC ❑

**Please note that if you are coming to camp from another country, it is your responsibility to have health insurance to cover any medical care that you may require outside of camp. Healthcare provided by camp's Body Shop staff is available to all at no cost.*

Height: ____________________________ inches / cm **Weight:** __________________________ lbs / kg

If you have any questions about this form, or about camp health services, please call our Nursing Team at 1-888-999-2267 or email nursing@camptrillium.com

Camp Trillium complies with the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Health Information Privacy Act (PHIPA) as it sets the ground rules for collecting personal information. Your health information will be used only for the purposes of providing screening and support to you while working/volunteering at camp and to provide health care as needed. It is treated as a confidential part of your health file at camp and in the care of the Health Care Team.

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Allergies	Yes	No	Unknown	Anaphylactic*	Please give details, past reactions and usual treatment
Food					
Bee Stings					
Medication					
Seasonal					
Other (latex, etc.)					
**all anaphylactic campers need to bring a prescription labeled, not expired epi-pen or similar device to camp.*					

Nutritional information: I **do not** eat the following:	Reason/details
❑ Red meat	
❑ Pork	
❑ Eggs	
❑ Dairy Products	
❑ Other	
❑ I'm a vegetarian, but I will eat fish (pescetarian)	
❑ I'm a vegetarian, but I will eat chicken	

** 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.*

Medication: *will you require medication while at camp?* ❑ Yes ❑ No ❑ Maybe

Please bring all medications usually taken, in original containers, and enough for your entire stay at camp. All medication must be stored in the locked staff/volunteer room in the Body Shop while you are at camp.				
Medication	**Dose**	**Times taken each day**	Reason/ Diagnosis	Special instructions

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General Physical/Occupational Health History:

Please indicate in the list below if you have any of the following health concerns, and if so, please provide us with some detail below the question

1. **Illnesses or injuries within the last year** ______ ❑ Yes ❑ No

   ______

2. **Chronic or recurring illnesses or conditions** ______ ❑ Yes ❑ No

   ______

3. **Major surgery, or permanent surgical devices** ______ ❑ Yes ❑ No

   If so, please describe: ______

   e.g., braces, retainers, surgical pins, plates, implants, etc.

4. **Neurological issues** (Regular headaches, dizziness, seizures, fainting, etc.) ______ ❑ Yes ❑ No

   If so, please describe: ______

5. **Vision or hearing** (glasses, hearing aids, etc.) ______ ❑ Yes ❑ No

   If so, please describe: ______

6. **Any piercings**: ______

7. **Mental health** (ADHD, depression, anxiety, panic attacks, gender identity concerns) ______ ❑ Yes ❑ No

   If so, please describe: ______

8. **Skin problems** (itching, rashes, acne, psoriasis)? ______ ❑ Yes ❑ No

   ______

9. **Antibiotic-resistant organism (ARO)?** ______ ❑ Yes ❑ No

   ______

10. **Cardiac issues** (heart attack, COPD, hypertension, blood disorder, etc.)? ______ ❑ Yes ❑ No

    ______

11. **Respiratory Issues** (Asthma, oxygen requirement, shortness of breath, etc.) ______ ❑ Yes ❑ No

    ______

12. **Endocrine Issues** (diabetes, hyper/hypoglycemia, hyper/hypothyroidism, etc.) ______ ❑ Yes ❑ No

    ______

13. **Bedtime/Overnight concerns** (nightmares, sleepwalking, night terrors, etc.) ______ ❑ Yes ❑ No

    ______

14. **Gastrointestinal/Genitourinary issues** ______ ❑ Yes ❑ No

    ______

    e.g., feeding tubes, ostomy, IBS, Celiac, constipation, menstruation, etc.

15. **Mobility concerns** (walker, cane, prosthetic, brace, wheelchair, limp, etc.) ______ ❑ Yes ❑ No

    ______

Health Concerns: *please indicate any specific health concerns as it relates to your job description or your participation at camp for your Camp Director/supervisor (more details can be added inside your health record).*

______

______

______

______

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Immunization Status: *(you may attach a photocopy of your up-to-date immunization record)*

MMR (Measles, Mumps, Rubella)	❑ I have been vaccinated	Date of vaccinations	1. ___ /___/____ (mm/dd/yy)	2. ___ /___/___ (mm/dd/yy)
	❑ I have not been vaccinated	Bloodwork to test for immunity Date:___/___/____ (mm/dd/yy)	Result: ❑ Immune	❑ Not immune
Chicken Pox (Varicella)	❑ I have had the chicken pox or shingles			
	❑ I have been vaccinated	Date of vaccinations	1. ___ /___/____ (mm/dd/yy)	2. ___ /___/___ (mm/dd/yy)
	❑ I have not had the chicken pox nor had the vaccine	Bloodwork to test for immunity Date:___/___/____ (mm/dd/yy)	Result: ❑ Immune	❑ Not immune
Tetanus/ Diphtheria/ Pertussis/ Polio	❑ I have been vaccinated	Date of last vaccination	________/________/________(mm/dd/yr)	
	❑ I have *not* been vaccinated			
Hepatitis B Vaccine	❑ I have been vaccinated	Date of vaccination series:____/____/____ (mm/dd/yy)	❑ 2 dose series	❑ 3 dose series
	❑ I have *not* been vaccinated			
Influenza Vaccine	❑ I have been vaccinated	Date of last vaccination	________ /________ /________(mm/dd/yr)	

Tuberculosis (TB) Status: ***A baseline documented 2-step TB skin test is required*** *before coming to camp for the first time followed by a yearly single step.*

Step 1	Date given	Location	Health Care Practitioner Signature
	Date read	Result (mm induration)	Health Care Practitioner Signature

Step 2 needs to be given in the other arm 1-3 weeks after the first one, and not longer than 4 weeks after Step 1.

Step 2	Date given	Location	Health Care Practitioner Signature
	Date read	Result (mm induration)	Health Care Practitioner Signature

If your 2 step is more than one year old, or it has been longer than one year since your last single step TB test, please have single step done here. *(remember to indicate above the dates/results of your previous 2 step testing**)***

Single Step	Date given	Location	Health Care Practitioner Signature
	Date read	Result (mm induration)	Health Care Practitioner Signature

****For any positive skin test of 10mm induration or greater, a chest x-ray is required**

X-Ray	Date:	Result	Health Care Practitioner Signature

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)

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