Camp AmeriKids ***(A Program of The ELM Project)***
88 Hamilton Avenue ● Stamford, CT 06902
Phone: (203) 658-9671 ● Fax: (203) 658-9615 ● volunteer@elm-project.org

2024 STAFF HEALTH FORM

This form must be filled out in its entirety and returned to the office ***by July 15th, 2024****.*
All Health Forms are kept confidential.

GENERAL INFORMATION

Name: _____ Gender: _____

Date of Birth: _____ Age: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Phone: _____ Alternate Phone: _____

MEDICAL INFORMATION

List any **pertinent medical information,** including mental health, that the Camp Infirmary should be aware of (for example, sickle cell disease, seizure disorder, asthma, anxiety disorder, HIV, etc.):

_____

_____

_____

_____

List all **current medications**: _____

_____

List all **drug and/or food allergies**: _____

_____

IMMUNIZATION DATES

*****You must provide the most up-to-date copy of your immunization's records to volunteer*****

Date of immunizations or blood test indicating immunity to **Measles/Mumps/Rubella** is REQUIRED by New York State. *Please note, if you were born before 1957 you are considered immune to MMR and do not need to provide a date or blood test.*

HIPAA FORM

Form is to be completed by Volunteer

Authorization to Release Protected Health Information

I, _____, hereby authorize The ELM Project, Inc.'s Camp Physician to use or disclose my protected health information (as defined herein) to the Camp Director and other medical or pertinent staff as is deemed necessary by the Director or the Camp Physician for my safety and wellbeing during the Camp AmeriKids program.

In addition, I authorize the Camp Physician to request, secure and use information regarding any prior and ongoing health condition and any prior and ongoing care and treatment from all health care providers holding such information (my "Protected Health Information") including, but not limited to, history and physical examination, admission and discharge summaries; operative reports; progress notes and nursing notes; laboratory reports; radiology reports; immunization records; billing summaries; consultation reports; pathology reports; psychological and psychiatric assessments; and medications.

I understand that in the event I was treated for drug or alcohol abuse, psychiatric condition, communicable diseases, including HIV/AIDS, this information will be included as part of my Protected Health Information.

I understand that the Camp Physician may not condition treatment or eligibility to participate in the Camp AmeriKids program on my signing this authorization.

I understand that this authorization is intended for use or disclosure of my Protected Health Information to the extent of and as permitted by the Standards for Privacy of Individually Identifiable Health Information (the so-called "Privacy Rule") issued by the U.S. Department of Health and Human Services to implement the requirement of the Health Insurance Portability and Accounting Act of 1996 ("HIPAA"). I have been given an opportunity to inquire and request information to my satisfaction regarding the requirements of the above law and regulations.

I understand that this authorization will expire automatically on the later of 90 days from the date hereof or the end of the camp period, and I also understand that I may cancel and revoke this authorization at any time effective upon my delivering written notice thereof to the Camp Physician or Camp Director except to the extent there has already been use or disclosure in reliance on this authorization.

_____

(Signature of Individual)

Social Security Number (required for background check): _____

Date of Birth: _____ Today's Date: _____

PHYSICAL EXAMINATION

To be completed by a licensed health care provider and submitted BEFORE the start of volunteering.

(1) Satisfactory (2) Not Satisfactory (3) Not Examined

Patient Name: _____

Patient Date of Birth: _____

Height: _____ **Weight:** _____ **BP** _____ **HR**_____

Eyes: _____ **Glasses:** _____ **Contacts:** _____

Ears: _____ **Hearing:** _____ **Right:** _____ **Left:** _____

Heart: _____ **Lungs:** _____ **Abdomen:** _____ **Hernia:** _____

Extremities: _____ **Skeletal:** _____ **Skin**_____

Restrictions: _____

Recommendation: _____

The above-named person is in satisfactory condition and may engage in all activities except as noted. I have found this person to be physically and emotionally healthy.

Date: _____ **Examining Physician:** _____

Telephone: _____ **Print Name:** _____

State License In: _____ **License Number** _____

Address: _____

PLEASE RETURN TO:
The ELM Project
88 Hamilton Avenue
Stamford, CT 06902
volunteer@elm-project.org
Fax: (203) 658-9615