TIC STAFF HEALTH FORM

First Name | **Last Name**

Camp(s):

☐ TIC-DC North ☐ TIC-MD

☐ TIC-DC West ☐ TIC-VA

IMMUNIZATIONS	Dose 1 Mo./Yr.	Dose 2 Mo./Yr.	Dose 3 Mo./Yr.	Dose 4 Mo./Yr.	Dose 5 Mo./Yr.	Most Recent Mo./Yr.
Diptheria, Tetanus*, pertussis (Dtap) or (TdaP)						
Tetanus Booster* (dT) or (TdaP)						
Mumps, measles, rubella (MMR)						
Polio (IPV)						
Haemophilus influenzae type B						
Pneumococcal (PCV)						
Hepatitis B						
Hepatitis A						
Varicella (chicken pox) ☐ Had chicken pox Date						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	☐ Negative ☐ Positive

*** Tetanus Required for all staff.**

If you have not been fully immunized, please sign the following statement: I understand and accept the risks from not being fully immunized.

Staff Member/Volunteer Signature: _____

Do you require any medications that might impair your ability to perform the essential functions of your position? ☐ NO ☐ Yes, Please expalin below

Important - This form must be signed and dated

Authorizations: This health history is correct and accurately reflects the health status of the staff member to whom it pertains. I can participate in all camp activities, except as noted. I give permission to the physician selected by the camp to order x-rays, tests, and treatment, if necessary. I understand the information on this form will be shared on a "need to know" basis with the camp nurse and administration.

Staff Member/Volunteer Signature: _____ Date: _____

- AND -

Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years): _____

Please send to forms@ticcamp.com

STAFF/VOLUNTEER HEALTH HISTORY

Staff Member's/Volunteer's Name: _____

The following information is required:

Emergency Contact Person: _____ Phone: _____

Primary Physician: _____ Phone: _____

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware? ☐ NO

   ☐ YES, Explain: _____

_____

_____

_____

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

   ☐ YES, Explain: _____

_____

_____

_____

IMMUNIZATION INFORMATION:

For staff members/volunteers who reside **within** the United States, a United States territory, or the District of Columbia:

1. State/territory in which person resides:

   _____

2. Is this person exempt from any immunizations? [ ] NO
   [ ] YES, List them: _____

   _____

   _____

OR ⟺

For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. Country in which person resides:

   _____

2. Attach Department form DHMH-896 (record of vaccination or immunity)

Print Form