

# 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.
Diphtheria, 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 <input type="checkbox"/> Had chicken pox (chicken pox)    Date <input style="width: 50px;" type="text"/>						
Meningococcal meningitis (MCV4)						

Tuberculosis (TB) test	Date:	<input style="width: 90%;" type="text"/>	<input type="checkbox"/> Negative <input type="checkbox"/> Positive
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**\* 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? <input type="checkbox"/> NO <input type="checkbox"/> Yes, Please explain below
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## 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): \_\_\_\_\_

**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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

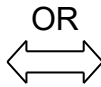
2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware?       NO

YES, Explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IMMUNIZATION INFORMATION:

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



For staff members/volunteers who reside **outside** 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: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

1. Country in which person resides:

\_\_\_\_\_

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