

# **CAMP LONGHORN INKS LAKE PIT STOP**

**#1 Camp Longhorn Rd  
Burnet, TX 78611  
512 793-2811 ext. 211**

Dear Counselors,

Camp Longhorn makes every effort to provide the best medical care for our counselors and campers. In order to do so, we require a medical form each year. Please note that we cannot use forms from the previous year because information changes and signatures must be current. We must have complete and accurate information on hand.

The staff medical form consists of 4 pages. The following information is required for each page:

- Page 1** is a general information/health history/authorization page. Please **complete** and **sign** this page as requested. If you are 18 years or older, you may sign the form yourself. Counselors younger than 18 will require a parent signature. Forms that are not signed or completed will be sent back.
- Page 2** consists of the physical exam form. If you are a **new** counselor, you are required to have a physical. Counselor physicals are good for 5 years. If you have been a counselor at Camp Longhorn, a label will be in place indicating the date of your last physical. If it is current, there is no need to complete this page.
- Page 3** is the HIPAA form. You may read the entire HIPAA agreement online at [www.camplonghorn.com](http://www.camplonghorn.com). If you are in agreement, please sign the bottom of the page. Same rule applies – if you are 18 years or older, you may sign –younger than 18, your parents must sign.
- Page 4** requests a copy of your insurance information. If you are self insured, please indicate so on the page.

If you are bringing medications to camp, you will need to bring them to the Pit Stop. No medications can be kept in the cabins. You may self-medicate while at camp.

The forms are due May 15<sup>th</sup>. We cannot have you at camp without these forms. Thanks so much for your attentiveness to the forms.

ATTAWAYTOGO!  
Camp Longhorn Pit Stop

**2010 CAMP LONGHORN STAFF MEDICAL FORM**  
**Return by: May 15<sup>th</sup>, 2010**

**PLEASE CIRCLE:**  
**CAMP:** Inks Lake Indian Springs **TERM:** 1st 2nd 3rd 4th

1. This form must be completed and signed. If under 18, this form must be signed by parents.
2. **PLEASE ENCLOSE A COPY OF YOUR MEDICAL INSURANCE AND PRESCRIPTION DRUG CARD (FRONT & BACK) & RETURN SIGNED HIPAA FORM.**
3. *You will be responsible for Non-Job related Medical Charges*

**Name** \_\_\_\_\_ **Birth Date** \_\_\_\_\_ **Age** \_\_\_\_\_ **Sex** \_\_\_\_\_  
 Last First MI  
 Parent or Guardian \_\_\_\_\_ Phone \_\_\_\_\_  
 Area/Number \_\_\_\_\_  
 Home Address \_\_\_\_\_  
 Street & Number City State Zip  
 Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Second Parent or Guardian or Emergency Contact: \_\_\_\_\_  
 Home Address \_\_\_\_\_ Phone \_\_\_\_\_  
 Street & Number City State Zip Area/Number  
 Work Phone \_\_\_\_\_

If not available in an emergency, notify:  
 Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Area/Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 Street & Number City State Zip

**HEALTH HISTORY** (Yes or No):

Frequent Ear Infections _____	<b>Diseases</b>	<b>Allergies</b>
Heart Defect/Disease _____	Chicken Pox _____	Ivy Poisoning Etc. _____
Seizure Disorder _____	Measles _____	Insect Stings _____
Diabetes _____	German Measles _____	Penicillin _____
Bleeding/Clotting Disorder _____	Mumps _____	Other Drugs _____
Hypertension _____		Asthma _____
Mononucleosis _____		Dietary _____

If yes to any of above, please explain. \_\_\_\_\_

Has this employee ever required any Psychiatric counseling or hospitalization? \_\_\_\_\_

Operations or serious injuries in past three years?: \_\_\_\_\_

Disability or Chronic or recurring illness: \_\_\_\_\_

Current Medications (send with instructions): \_\_\_\_\_

Other diseases or details of above: \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**IMMUNIZATION HISTORY** Please record the date (month & year) of most recent booster doses.

\*\* Not required but if you have this Vaccine, please record date **MENINGOCOCCAL** \_\_\_\_\_

VACCINES	DATE OF LAST BOOSTER
TD Tetanus, Diphtheria	
Tetanus	
MMR Measles, Mumps, Rubella	

You will be covered while employed by Camp Longhorn's worker compensation insurance for job related injuries and illnesses. All other medical care will be your responsibility. I hereby give permission to the Camp:

1. To provide ongoing health care.
2. To select medical personnel and to order X-rays or routine test or treatment for the person listed above.
3. To provide transportation in Camp's vehicles to out of camp medical care providers as necessary.
4. To allow any photos or videos of employee produced by Camp Longhorn to be used by Camp Longhorn in any of its publications or promotional media. You may revoke this authorization at any time in writing which is signed by employee or parent and delivered to and acknowledged in writing by Camp Longhorn.

**Emergency Authorization:** In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the Camp Director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for the person named above. This form may be photocopied for use out of camp.

**Signature of employee (if over 18) or parents/ guardians:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Name \_\_\_\_\_

**HEALTH EXAMINATION BY LICENSED PHYSICIAN**

I have examined the above camp applicant. Date Examined: \_\_\_\_\_

In my opinion, the condition of the camp applicant (does allow \_\_\_\_ ) (does not allow \_\_\_\_ ) the applicant to participate in an active camp program.

The applicant is under the care of a physician for the following condition(s):

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

Current treatment (include current medications): \_\_\_\_\_

Explanation of any reported loss of consciousness, convulsion, or concussion: \_\_\_\_\_

Does applicant have epilepsy? Yes \_\_\_ No \_\_\_ Does applicant have Diabetes? Yes \_\_\_ No \_\_\_

**RECOMMENDATIONS AND RESTRICTIONS WHILE AT CAMP:**

Any treatment to be continued at camp: \_\_\_\_\_

Any medication to be administered at camp (specific doses): \_\_\_\_\_

Any Allergies (food, drugs, plants & insects, etc.): \_\_\_\_\_

Type of reaction: \_\_\_\_\_

Additional Health Information: \_\_\_\_\_

Licensed Physician's Signature: \_\_\_\_\_ Phone: \_\_\_\_\_  
Area/Number

Address: \_\_\_\_\_  
Street & Number City State Zip

Date of Form Completion: \_\_\_\_\_ \*By: \_\_\_\_\_  
\*Initial if completed by nurse or physician's assistant.

**CAMP LONGHORN INKS LAKE**

**CAMP LONGHORN INDIAN SPRINGS**

The following is in compliance with the **HIPAA** law effective April 1, 2003. The entire Privacy Policy is listed on our Camp Longhorn website [www.camplonghorn.com](http://www.camplonghorn.com). Go to the homepage and “click” on HIPAA/Privacy Policy. If you do not have access to our website, you may request a copy in writing. Please send requests to:

Deidra Robertson  
Camp Longhorn Inks Lake  
#1 Longhorn Rd.  
Burnet, TX 78611

Rosa Ontiveros  
Camp Longhorn Indian Springs  
1000 Indians Springs Rd  
Burnet, TX 78611

**PRIVACY POLICY**

We understand that medical information about you is personal. We are committed to protecting medical information about you. We create a record of care and services you receive to provide quality care and to comply with legal requirements. This notice applies to all of the records of your care that we maintain. We are required by law to:

- Keep medical information about you private.
- Give you the notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

We may change our policies at any time. Changes will apply to medical information we already hold, as well as new information after the changes occurs. We may use and disclose medical information about you for treatment (such as sending medical information to a specialists as part of a referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicaid); and to support health care operations (such as comparing patient data to improve treatment methods.)

We may use or disclose medical information about you without your prior authorization for several reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes, abuse or neglect reporting, health oversight audits or inspections, research studies, worker’s compensation purposes, and emergencies. We also disclose medical information when required by law, such as in response to request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders. We may disclose medical information about you to a friend or family member who is involved in your medical care or to disaster relief authorities so that your family can be notified of your location and condition.

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information. If you choose to authorize use or disclosure you can later revoke that authorization by notifying us in writing about your decision.

**Acknowledgement of Review of Notice of Privacy Practices**

**I have reviewed this office’s Notice of Privacy Practices, which explains how my medical information will be used and disclosed.**

Camper/Counselor Name \_\_\_\_\_ Date \_\_\_\_\_

Signature (Parent/Guardian or Counselor) \_\_\_\_\_

**18 years or older**

**PLEASE TAPE A COPY OF YOUR INSURANCE CARD(S) HERE.**

FRONT  
MEDICAL INSURANCE CARD

BACK  
MEDICAL INSURANCE CARD

FRONT  
MEDICAL PRESCRIPTION CARD

FRONT  
MEDICAL PRESCRIPTION CARD