2020-21 STAFF/VOLUNTEER INFORMATION AND HEALTH FORM

For staff and volunteers who work at SEA events

Name: _____ **SEA member program:** _____

Cell phone: _____ **Sex:** _____ **Date of birth:** _____

Home address: _____

Street & Apt City, State Zip Code

Emergency Contact #1

Name: _____

Relationship: _____

Cell phone #: _____

Home phone #: _____

Work phone #: _____

Emergency Contact #2

Name: _____

Relationship: _____

Cell phone #: _____

Home phone #: _____

Work phone #: _____

Do you have **allergies** that SEA should be aware of? **YES** **NO**

If yes, please describe: _____

Do you have **any medical conditions** that SEA should be aware of? **YES** **NO**

If yes, please describe: _____

Do you regularly take **medication(s)** that SEA should be aware of? **YES** **NO**

If yes, please describe: _____

If you are participating in SEA's Summer Camps, please complete page 2 of this form. Otherwise, you only need to complete page 1.

SEA 2020 - 2021 PARTICIPANT HEALTH FORM (Summer Camps Only)

To be completed by a physician or nurse practitioner. This form may be substituted by submitting both (1) a list of immunizations from a doctor's office and (2) a copy of a physical examination completed within the past 18 months detailing medications, allergies and/or dietary restrictions, past medical treatments, and any physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while in the program.

Participant full name: _____ Sex: _____ Date of birth: _____

Address (street, city, state): _____

Parent/Guardian Name(s): _____

Students are required to be immunized with the following. Please list specific dates for all immunizations or attach a form from the physician with this information.

Diphtheria, Tetanus, Pertussis (DTaP/DTP/DT/Td) (5): _____ _____ _____ _____ _____

Td/Tdap for grade 7 (age 12) thru college* (1): _____ Tetanus/diphtheria (td) Booster: _____
** Everyone else is required to have a dose of Tdap/Td if it has been more than 10 years since the previous dose of Td.*

Polio (OPV/e-IPV) (4):_____ _____ _____ _____
3 doses are acceptable if the 3rd dose is given on or after the 4th birthday and ≥6 months after the previous dose.

MMR (2): _____ _____OR Laboratory evidence of immunity

Hepatitis B (3): _____ _____ _____ OR Laboratory evidence of immunity

Varicella vaccine (2): _____ _____ OR – healthcare provider certified history of chickenpox disease.

Date of last complete physical exam:_____ *(must be within 18 months of SEA event)*

Height_____ Weight_____ Blood Pressure:_____/_____ Hct. or Hgb.:_____ TB test_____

Any significant illness or injuries since last physical exam? _____

General estimate of health:_____

Please list **medications** to be administered out while participating (including over-the-counter drugs):

_____

Please list **allergies and/or health conditions** such as asthma, etc., which may affect the student's activities:

_____

Name of health care provider:_____

Address of health care provider:_____

Health care provider phone:_____

Signature of examining physician/nurse practitioner:_____