VOLUNTEER HEALTH INFORMATION FORM

COMPLETE AND BRING TO CAMP WITH YOU

PLEASE PRINT Date_____

Last Name _____First Name _____

Home Address _____

Birth Date _____ Weight _____ Height _____ Male _____Female _____

Emergency Contact _____ Phone # _____

Home Address _____

Business Address _____Phone #_____

Emergency Contact _____ Phone # _____

Home Address _____

Business Address _____Phone #_____

Primary Care Physician _____ Phone # _____

Hospital Preference _____

Please list any pertinent information concerning physical, psychiatric or behavioral conditions?

_____

_____

_____

Allergies (including medicines) _____

Have you been hospitalized or had outpatient surgery in the past two years? _____ Yes ___ No

If yes please explain _____

Have you had any psychological counseling or hospitalization? ____Yes ___No

If yes please explain _____

Date of last tetanus shot _____

If under 18, have you had all the immunizations required by your public/private school system?

_____ Yes _____ No Name of school system _____

(If you are under the age of 18, please provide documentation of school

Please be sure to complete BOTH sides

enrollment or documentation of age appropriate immunizations.)

Health Care Provider will administer the following over-the-counter medications or the generic version if necessary. Dosages will be administered to directions on the bottles unless a physician directs otherwise.			
Symptom	*Medication*	***Symptom***	***Medication***
Minor aches/pain/fever	Tylenol/Motrin	Minor cough/sore throat	Cough drops
Minor allergic reactions/allergies	Benadryl	Poison Ivy/Rashes	Calagel Lotion
Diarrhea	Kaopectate	Bug Bites	Benzocaine Swabs
Indigestion/heartburn	Antacid	Jelly Fish Stings	Alcohol/meat tenderizer/ Baking soda/ or hydrocortisone cream
Constipation	Milk of Magnesia		

IN CASE OF EMERGENCY I understand every effort will be made to contact the person(s) I have named on this form. In the event of an emergency and they cannot be reached, I hereby give permission to the medical personnel selected by the Camp Manager/Director to hospitalize, secure proper treatment for, and to order injection, and/or anesthesia and/or surgery for myself/ (my child) as named above. This form may be photocopied for use out of camp.

Signature: _____

Signature of Parent (if under 18 yrs old) _____

Date: _____

IF TAKING MEDS: Any volunteer over 18 years of age can store and administer their own medications. Please be sure all medications are kept secure in your own belongings and are not accessible to campers. You must still turn in the health form for emergency purposes only.

Do you take any medications on a routine basis? ___Yes __ No

Please list medication and reason for taking.

_____

_____

_____

Do you have any dependents at camp for which arrangements need to be made in an emergency?_____

Please attach specific instructions if you would like someone to assist in your dependent care in the event you become unable to do so yourself.

Name of Local Church _____ Pastor _____

I hereby declare that the information listed on this form is true and correct to the best of my knowledge and that I have read and understand all of the information.

Signature: _____ Date: _____

Please be sure to complete BOTH sides

Please be sure to complete BOTH sides