

# VOLUNTEER/STAFF HEALTH FORM -2011

We prefer you mail this form to us one week before arriving to camp if not, You must bring this completed two page form with you to Camp on the day of Check In.

Participants will not be allowed to stay at camp without completing and returning this form to the office for filing. Activities you/child could possibly be involved in at camp but not limited to: Bible lesson, worship, cookouts, horseback riding, boating, hiking, swimming, fishing, crafts, wagon ride, archery, initiatives games, field sports, and low ropes activities. Persons with special needs are encouraged to contact the Camp Director or other site staff before coming to camp.

Volunteer/STAFF Name: \_\_\_\_\_  
 D.O.B. \_\_\_/\_\_\_/\_\_\_ Cell-phone # \_\_\_\_\_ Home-phone# \_\_\_\_\_  
 Home address \_\_\_\_\_  
 \_\_\_\_\_

### Parent/Guardian - Emergency Information (for those 18yrs. And younger)

Father/Guardian's name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone #'s Home \_\_\_\_\_ Office \_\_\_\_\_  
 Cell \_\_\_\_\_

Mother/Guardian's name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone #'s Home \_\_\_\_\_ Office \_\_\_\_\_  
 Cell \_\_\_\_\_

**Emergency Contact Person** -Name \_\_\_\_\_  
 Their Relationship to Camper \_\_\_\_\_  
 Phone #'s Home \_\_\_\_\_ Office \_\_\_\_\_  
 Cell \_\_\_\_\_

### Doctor Information

Doctor's name \_\_\_\_\_ Office Number \_\_\_\_\_  
 Date of last health examination: \_\_\_\_\_ (must be within past 2 years)

Are immunizations current for the person:  Yes,  No. Date of LAST TETNUS SHOT - \_\_\_/\_\_\_/\_\_\_

This individual is physically fit to participate in camp he/she is registered for:  Yes  No

Signature of Doctor: \_\_\_\_\_ Date: \_\_\_\_\_  
(Must have Doctors Signature if your child is taking any type of medication (even if they are over the counter meds) on a regular basis)

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

**Check each area as it applies**, so that our Health Supervisor will be aware of the needs of you/your child.

- |  |  |   |
|--|--|---|
| Yes No   | Yes No   | Yes No  |
| <input type="checkbox"/> <input type="checkbox"/> current tetanus protection | <input type="checkbox"/> <input type="checkbox"/> history of chronic infection                       | <input type="checkbox"/> <input type="checkbox"/> diabetes      |
| <input type="checkbox"/> <input type="checkbox"/> heart condition            | <input type="checkbox"/> <input type="checkbox"/> skin diseases                                      | <input type="checkbox"/> <input type="checkbox"/> fainting      |
| <input type="checkbox"/> <input type="checkbox"/> regular medications        | <input type="checkbox"/> <input type="checkbox"/> food restrictions                                  | <input type="checkbox"/> <input type="checkbox"/> hearing aid   |
| <input type="checkbox"/> <input type="checkbox"/> allergies to bee stings    | <input type="checkbox"/> <input type="checkbox"/> asthma   | <input type="checkbox"/> <input type="checkbox"/> ADD/ADHD      |
| <input type="checkbox"/> <input type="checkbox"/> convulsions/seizures       | <input type="checkbox"/> <input type="checkbox"/> nose bleeds  | <input type="checkbox"/> <input type="checkbox"/> bed wetting   |
| <input type="checkbox"/> <input type="checkbox"/> wear contact lens          | <input type="checkbox"/> <input type="checkbox"/> other significant allergies                        | <input type="checkbox"/> <input type="checkbox"/> sleep walking |
| <input type="checkbox"/> <input type="checkbox"/> menstruated (females only) | <input type="checkbox"/> <input type="checkbox"/> blood disorder ( explain under chronic conditions) |   |

PLEASE COMPLETE BOTH SIDES OF THIS FORM

Vol./Staff Name \_\_\_\_\_

Camp Code # \_\_\_\_\_

Week of \_\_\_\_\_

2011 - Volunteer/STAFF HEALTH FORM (Side 2)

Complete all areas and return as soon as possible to the Camp Office 2577 Idaho RD Ottawa 66067

Week of

Camp Code #

VOL./Staff Name

**Medications:** list prescription, dosage, frequency; medications brought to camp must be in ORIGINAL containers, clearly labeled, and placed in a ziploc bag with the individual's name on it.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Drug allergies or other chronic conditions:** list other conditions that require ongoing attention.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**Physical Restrictions:** list chronic conditions that restrict activity; i.e. heart, lung, arthritis, etc.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

**ARE there any Camp Activities this person should be exempt from for health reasons? (Please list)**

- 1. \_\_\_\_\_ 2. \_\_\_\_\_
- 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Food restrictions:** list food allergies, restrictions due to prescriptions, etc.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_

I give permission for Camp Chippewa to administer over-the-counter medications for those items checked "YES" below if the Health Supervisor deems it necessary. Dosages will be administered according to directions on the bottle unless a physician directs otherwise.

- |     |     |                              |                               |     |
|-----|-----|------------------------------|-------------------------------|-----|
| Yes | No  |                              | Yes                           | No  |
| ( ) | ( ) | ear drops for swimmer's ear? | ( )                           | ( ) |
| ( ) | ( ) | antacids for upset stomach ? | ( )                           | ( ) |
| ( ) | ( ) | cough medicine/cough drops?  | ( )                           | ( ) |
| ( ) | ( ) | Benadryl/diphenhydramine?    | ( )                           | ( ) |
| ( ) | ( ) | Medication for diarrhea?     | ( )                           | ( ) |
|     |     |                              | ( )                           | ( ) |
|     |     |                              | Caladryl lotion ?             |     |
|     |     |                              | Tylenol/acetaminophen?        |     |
|     |     |                              | Motrin/ibuprofen?             |     |
|     |     |                              | Sudafed/pseudoephedrine?      |     |
|     |     |                              | throat lozenges for soreness? |     |

**PARENT'S/GUARDIAN/SELF CONSENT FOR MEDICAL TREATMENT AND MEDICATIONS**

I hereby give my permission to the medical personnel selected by the Camp Director/Site Director to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide for or arrange necessary related transportation for my child/or myself. I also give my permission to release information on this form for the purpose of assisting with medical treatment.

In the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by the Camp Director/Site Director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips off site of the camp. I also understand the Camp Staff will contact me or my emergency contact person(s) as soon as they are able in the event of any such emergency that concerns my child or myself.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Participating Adult \_\_\_\_\_ Date \_\_\_\_\_