Redwood Glen's 2017 Volunteer Health Form

Volunteer Name_____ Dates of volunteer_____

COMPREHENSIVE HEALTH HISTORY, PHYSICIAN INFORMATION AND EMERGENCY AUTHORIZATION

(Please note: During check-in on registration day we will have a 'health screening' where we will check you for lice, ask for all medications to be turned in, ask about any recent injuries, exposure to any communicable diseases, and if there have been any changes in your health/usage of meds since completing this form)

Physician and Insurance Information

_____ (____)_____
Doctor's Name Doctor's Phone Number

_____ _____
Insurance Company Policy Number

Note: Your Insurance is considered the primary insurance in the event of an accident or health problem while you are volunteering at camp. (Redwood Glen does; however, carry accident insurance in the event there is no family accident insurance.)

Have you had a physical in the last 24 months?_____
Please attach a copy of physical to this form. *(Recommended, **not required**.)*

Please list any special limitations or restrictions (eg. diet, glasses/contacts, retainers, hearing aids, sleepwalking, medical devices in use, hospitalizations or surgeries, socialization issues, etc.)_____

MEDICATIONS (List with instructions) Note: All prescription medications must carry Pharmacist's label and be in original containers. All medications will be kept secure by the camp's Health Care Provider and made available as prescribed. Volunteers may not bring over-the-counter medications, unless they have written instructions from a licensed physician. Over-the-counter medications will be made available by the camp's Health Care Provider according to written, health-care policies and procedures.

AUTHORIZATION/COMMITMENT

I certify that I am able to fully participate in the camp(s) I am applying for, unless restrictions are noted above. I understand that I may be transported in camp-designated vehicles for off-site trips and for emergency and routine medical care. I give permission to search my belongings, while present, when the health, well-being, or safety of myself or others requires it.

I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications (prescription and over-the-counter); to order X-rays, routine tests, and/or treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me. In the event I am unconscious in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for me. This completed form may be photocopied for trips out of camp.

I authorize the investigation of all statements herein and release the camp and all others from liability in connection with the same. I understand that untrue, misleading or omitted information herein may result in termination of my volunteer services, regardless of the time of discovery.

_____ _____ ___/___/___
Applicant Signature Print Name Date

_____ _____ ___/___/___
Parent/Guardian Signature *(required, if applicant is a minor)* Print Name Date

Health History

I have or have had the following:

Allergies/Dietary Restrictions:

☐ If checked, please specify (eg. Hay Fever, Poison Oak/Ivy, Insect Stings, Pollen, Penicillin, or specific foods, drugs, or other): _____

Neuro/Psychological:

☐ If checked, please specify (eg. ADD/ADHD, Epilepsy, Concussion, Convulsions, etc.):_____

Diseases:

☐ If checked, please specify (eg. Chicken Pox, Measles, German Measles, Mumps, Scarlet Fever, etc.):_____

Other:

☐ If checked, please specify (eg. Rheumatic Fever, Fainting, Diabetes, Asthma, AIDS, etc.):_____

Immunization History

Please provide dates (mo/yr) of all immunizations or a copy of your records.

___/___ DPT Series
___/___ Polio
___/___ MMR (Measles/mumps/rubella)
___/___ Tuberculin test
___/___ Tetanus booster
___/___ Hepatitis B
___/___ Haemphilus Influenza (HIB)
___/___ Other

Emergency Contact Person: _____ Phone # (___)_____ Alternate # (___)_____ Relationship to you: _____

Nurse's notes: _____