



## Volunteer Health Form

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_  
Address \_\_\_\_\_

\_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

**Person to contact in case of emergency:**

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Day phone (\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

**Medical Information:**

Name and address of physician \_\_\_\_\_

\_\_\_\_\_ Physician Phone (\_\_\_\_) \_\_\_\_\_

Health insurance plan/carrier \_\_\_\_\_

Policy number \_\_\_\_\_

**General Health History:**

**Do you have a history of any of the following? (check all that apply)**

Asthma \_\_\_\_\_ Ear infections \_\_\_\_\_ High blood pressure \_\_\_\_\_ Seizures \_\_\_\_\_ Heart disease \_\_\_\_\_

Blood disorder \_\_\_\_\_ Arthritis \_\_\_\_\_ Headaches \_\_\_\_\_ Diabetes \_\_\_\_\_ Other \_\_\_\_\_

Please describe in more detail any of the above that are checked: \_\_\_\_\_

\_\_\_\_\_

**Allergies: (please check all that apply)**

Hay fever \_\_\_\_\_ Poison Ivy \_\_\_\_\_ Bee/insect stings \_\_\_\_\_ Food \_\_\_\_\_ Medications \_\_\_\_\_

Other \_\_\_\_\_

Please describe in detail allergic reactions to any of the above that are checked: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list any restrictions or limitations you may have as a result of any medical conditions:**

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**Medications being taken: (please list ALL medications being taken including OTC or non-prescription drugs)**

<b>Drug</b>	<b>Dose</b>	<b>Frequency</b>

**Immunization History: (please provide dates, estimated dates or dates of titers)**

Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_  
Varicella (chicken pox) \_\_\_\_\_ Tetanus \_\_\_\_\_  
Hepatitis B series completion date (not required) \_\_\_\_\_

In signing this form, I swear that the information contained herein is complete and true. I give permission for Camp No Worries medical staff to administer any routine and/or emergency first-aid. I understand that every effort will be made to contact named emergency person, but in the event that they can not be reached, I hereby give permission to Camp No Worries medical staff to hospitalize and/or secure proper medical treatment as needed.

**Applicant's signature** \_\_\_\_\_ **Date** \_\_\_\_\_