

CAMP HOPE ADULT MEDICAL FORM / PERMISSION TO TREAT

I. Volunteer Information

Volunteer Legal last and first name _____ SSN _____

Age _____ DOB _____ Male__ Female__ (Please Check)

Home Address: Street _____ City _____

State _____ Zip Code _____ Cell phone (_____) _____ - _____

II. Emergency Contacts (2 contacts mandatory)

1. Name/Relationship to volunteer _____

Home/Cell/work numbers _____

2. Name/Relationship to volunteer _____

Home/Cell/work numbers _____

III. Insurance Information

Medical Insurance Company _____ Subscriber _____

ID Number _____ *MANDATORY - Attach a photo of both sides of card

PHYSICIAN NAME _____ Phone Number (_____) _____ - _____

Additional Physician Name _____ Phone Number (_____) _____ - _____

ALLERGY INFORMATION: List any allergies to foods, meds, animals, insects, plants or other

For severe Allergies, Asthma, Diabetes or any health issue requiring a nurse's care, you MUST provide a mandatory doctor prescribed protocol AND signature

IV. Medical Information

A. History: (Check if Yes)

| | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Menstrual problem | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Glasses | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Stomach/Bowel problem | <input type="checkbox"/> Contacts | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Speech problem | <input type="checkbox"/> Vision problem | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Lung disease/condition | <input type="checkbox"/> Kidney/Bladder problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Orthopedic problems | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Nasal/Sinus problem | <input type="checkbox"/> Asthma | <input type="checkbox"/> Head Injury |

*IF YOU CHECK YES FOR ANY ABOVE ITEMS PLEASE PROVIDE A WRITTEN EXPLANATION IN FULL

• Can you participate in all activities: YES _____ NO _____ IF NO EXPLAIN:

• Please list and explain any general health issue(s) that require ongoing care/nurse's care

• Height _____ Weight _____ Date of last tetanus shot _____ (mandatory)

• Dietary restrictions or concerns (please be specific with severe allergies and dietary needs)

___ Social/psychological (ADD, learning disability, anxiety, depression, etc.)

EXPLAIN: _____

___ Behavioral Issue

EXPLAIN: _____

___ Surgical /serious illness /or injury within the last year

EXPLAIN: _____

___ Physical Limitation or Other

EXPLAIN: _____

****Foreign adult volunteers must submit current TB results or provide a doctor's note that they are clear***

List any medications regularly used:

B. AUTHORIZATION: (Read all information and sign) I have fully, accurately, and to the best of my knowledge completed this history. I understand this information will be shared only on a medical/camp need-to-know basis. I hold the Camp Staff harmless in connection with the administration of medications and treatments. In the event of an emergency, I hereby give permission to the Camp Staff to secure treatments and emergency care for myself. I understand I am financially responsible for any/all medical bills/copays incurred, including payments incurred not covered by my insurance. I have attached a copy, front and back, of my insurance card.

Printed Name of Individual

SIGNATURE: _____ **Date** _____

CAMP HOPE MEDICATION USE & PERMISSION FORM

PLEASE FILL OUT ONE FORM PER INDIVIDUAL ATTENDING CAMP HOPE

FOR CAMPERS / COUNSELORS under 18 – This Form must be completed by a Parent and Doctor for any camper/counselor taking any medications of any kind - (prescriptions, over-the-counter, vitamins, herbals). Individuals under 18 years of age taking routine medications MUST have a signed permission for administration from both the physician and the parent.

FOR COUNSELORS / STAFF 18+ – This Form must be completed by any individual (18+) taking any medications of any kind. (prescriptions, over-the-counter, vitamins, herbals)

LAST NAME _____ FIRST NAME _____ DATE _____

Medications for any individual will be administered by nurses at Camp Hope.

- If a child must carry an emergency medication such as an inhaler or Epi-pen, the doctor must provide specific permission/instructions for carrying and self-administering medication at camp.
- All meds and permission forms will be handed to nurse upon arrival at Camp Hope. Please plan to review administration with nurse and your child.
- Prescription drugs must be in original bottle, with date for this year and labeled for the specific child. Label every prescription box/non-prescription container/equipment with child's name.
- Package all medications for each child in a large Ziploc bag and label with child's name.

| MEDICATION | DOSE | FREQUENCY | REASON FOR MEDICATION |
|------------|------|-----------|-----------------------|
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I hereby authorize this individual / child to receive the above medications while at Camp Hope.

Individual (if 18+) Name: _____ Individual Signature: _____

Parent and Doctor sign below for any camper / counselor under 18.

Parent/Guardian Name: _____ Parent Signature: _____

Physician Name: _____ Physician Signature: _____