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)

___ Allergies	___ Menstrual problem	___ Bedwetting
___ Sleepwalking	___ Glasses	___ Diabetes
___ Stomach/Bowel problem	___ Contacts	___ Eating Disorder
___ Speech problem	___ Vision problem	___ Fainting
___ Lung disease/condition	___ Kidney/Bladder problems	___ Heart Disease
___ Hearing Difficulty	___ Orthopedic problems	___ Hypertension
___ Nasal/Sinus problem	___ Asthma	___ Head Injury

*IF YOU CHECK YES FOR ANY ABOVE ITEMS PLEASE PROVIDE A WRITTEN EXPLANTION 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)
- Have you received a COVID19 Vaccination? YES____ NO____ If YES, date of final shot _____

• 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 including but not limited to COVID19 testing. 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

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: _____