

# 2010 VOLUNTEER MEDICAL FORM

# CAMP OTYOKWAH

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ M \_\_\_\_ F \_\_\_\_

**Medical Insurance**  Check box to show copy of medical card attached

Family Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_

Parent/Guardian or Spouse \_\_\_\_\_

**Date of Last Tetanus Shot:**

\_\_\_\_\_  
If more than 10 years ago, should have booster before coming to

**Special Conditions/Health History: (please check)**

\_\_\_\_ Allergies                      \_\_\_\_ Hayfever/asthma                      \_\_\_\_ Convulsions/Seizures  
\_\_\_\_ Heart trouble                      \_\_\_\_ Diabetes                      \_\_\_\_ Recently exposed to infectious diseases  
\_\_\_\_ Other: please explain \_\_\_\_\_

<b>Surgeries and/or Hospitalizations:</b>	Date	Reason
_____	_____	_____
_____	_____	_____

<b>Allergies to Medications:</b>	Medication	Type of Reaction
_____	_____	_____
_____	_____	_____

How do you react to injury or illness? (i.e. pain tolerance, minimize injury, dramatic, etc.)

Please include other information that will be helpful in an emergency

**Medications:**

Note: The resident Health Professional functions under the direction of a medical director. **Medications may only be administered if in the ORIGINAL BOTTLE.** Medications in plastic bags or other pill containers cannot be dispensed. Medications prescribed to someone other than the camper may not be dispensed.

Medications to be taken during camp:

Name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

**REQUIRED FOR EACH ADULT VOLUNTEER:**

If I am not able to give permission for emergency medical treatment and my primary contact cannot be reached in an emergency, I give permission to Camp Otyokwah Personnel to provide emergency medical treatment, including hospitalization, for me. I also give the resident health professional permission to administer nonprescription medications as deemed necessary.

Volunteer's Signature _____	Additional Emergency Contact: _____
Primary Emergency Contact _____	Relationship _____
Address _____	Phone (H) ____ - ____ - ____
Phone (H) ____ - ____ - ____ (W) ____ - ____ - ____ (C) ____ - ____ - ____	(W) ____ - ____ - ____
	(C) ____ - ____ - ____

**REQUIRED FOR EACH VOLUNTEER WHO IS A MINOR:**

If I cannot be reached in an emergency, I give permission to Camp Otyokwah Personnel to provide emergency medical treatment, including hospitalization, for my child. I also give the resident health professional permission to administer nonprescription medications as deemed necessary.

Parent/Guardian's Signature _____	Additional Emergency Contact: _____
Parent/Guardian's Name (printed) _____	Relationship _____
Address _____	Phone (H) ____ - ____ - ____
Phone (H) ____ - ____ - ____ (W) ____ - ____ - ____ (C) ____ - ____ - ____	(W) ____ - ____ - ____
	(C) ____ - ____ - ____