2020 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 _____

Surgeries and/or Hospitalizations:

Date	Reason
_____	_____
_____	_____

Allergies to Medications:

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 _____

Primary Emergency Contact _____

Address _____

Phone (H) ____-____-_____ (W) ____-____-_____ (C) ____-____-_____

Additional Emergency Contact:

_____

Relationship_____

Phone (H) ____-____-_____

(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 _____

Parent/Guardian's Name (printed) _____

Address _____

Phone (H) ____-____-_____ (W) ____-____-_____ (C) ____-____-_____

Additional Emergency Contact:

Relationship_____

Phone (H) ____-____-_____

(W) ____-____-_____

(C) ____-____-_____