

# 2021 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 # \_\_\_\_\_

Special Conditions/Health History: (please check)

Date of Last Tetanus Shot: \_\_\_\_\_

If more than 10 years ago, you should have a booster before coming to camp.

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

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

Surgeries and/or Hospitalizations: \_\_\_\_\_

Date Reason \_\_\_\_\_

\_\_\_\_\_

Allergies to: \_\_\_\_\_ Medication Type of Reaction

Allergic to the following medications: \_\_\_\_\_

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 \_\_\_\_\_ 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) \_\_\_\_-\_\_\_\_-\_\_\_\_