TEPEE BIBLE CAMP STAFF MEDICAL FORM

Volunteer staff members please fill out this entire form placing the letters NA for any area that is not applicable. The dates (Approx. month and Year) of all immunizations are required by the State of Colorado Department of Health. Any form that is not completely filled out will be returned to you and will delay your acceptance as a staff member. <u>Please have your medical practitioner (may use a chiropractor certified to give DOT physicals) examine you and sign the lower portion of this form. You only need a complete physical every 24 months but your medical practitioner must do a well check and sign the form.</u>

NAME_____SEX____
MAILING ADDRESS_____
CITY_____ST_____ZIP_____
PHONE (____) _____DATE OF BIRTH_____

DATE OF MOST RECENT PHYSICAL EXAM (must be within the past 24 mos.) _____

INSURANCE NAME AND GROUP #_____

List two persons and their phone numbers to contact in case of emergency:

NAME:_____PHONE(____)_____
NAME:_____PHONE(____)_____
List any communicable diseases and/or illnesses or surgeries including seizures:
_____
_____
_____

List any drug reactions and allergies which you may have including food allergies:
_____
_____
_____
List any prescriptive or non-prescriptive medications which you are currently taking:

Name of Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any Special medical diets: Yes____ No_____ If yes, explain:
_____
_____
_____

Immunization record: Please list **month and year** of latest immunization.
Tetanus:_____DPT_____Polio_____Measles_____
Hepatitis B_____ Other_____

For persons 18 or older: I hereby give my permission to camp officials to seek medical treatment for me in case of an emergency and I give the staff medical person permission to administer the over-the-counter medications listed on the opposite page.

_____ _____
(**SIGNATURE OF VOLUNTEER STAFF MEMBER)** **(DATE)**

IF YOU ARE UNDER THE AGE OF 18 PLEASE HAVE YOUR PARENT FILL OUT ALL AREAS OF THE REMAINING PORTION OF THIS FORM. THE PARENT MUST THEN SIGN AND DATE THE FORM. THIS IS A COLORADO DEPARTMENT OF HEALTH REQUIREMENT AND A REQUIREMENT FOR ACCEPTANCE AS A CAMP VOLUNTEER STAFF MEMBER.

NAME OF PARENT OR GUARDIAN:_____
PARENT ADDRESS_____
RESPONSIBLE PARENTS EMPLOYER'S NAME:_____
_____PHONE_____

I hereby give my permission to camp officials to seek medical treatment for my minor child in case of an emergency and I give the staff medical person permission to administer the over-the-counter medications listed on the opposite page.

_____ _____
(**SIGNATURE OF PARENT OR GUARDIAN)** **(DATE)**

----------FOR DOCTOR'S USE ONLY----------

I have examined this staff member and found him/her to be in satisfactory physical condition, free from any communicable disease and capable of active participation in a regular camp program including the 11 mile intermediate hike except as follows:

_____
_____
_____
_____
_____

_____ _____
Signature of Medical Practitioner **Date**