TEPEE BIBLE CAMP STAFF HEALTH HISTORY

Volunteer staff members please fill out this entire form placing the letters NA for any area that is not applicable. Any form that is not completely filled out and signed will be returned to you and will delay your acceptance as a staff member. <u>You must have your medical practitioner (Physician, PA, Naturopath, etc) sign the lower portion of this form every 2 years.</u>

NAME_____SEX____Date of Birth_____
MAILING ADDRESS_____
CITY_____ST_____ZIP_____ PHONE (____) _____

INSURANCE NAME AND GROUP #_____
Date of most recent Physical exam:_____

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: Use back of page for more if needed.

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

Any Special medical diets: Yes____ No_____ If yes, explain: (use back of this page if needed)

Immunization record: Please list **<u>month</u> <u>and year</u>** of latest immunization. Or you may attach a copy of your immunization card or statement of exemption. **<u>You must have a current DPT or Tdap (within the last 9 years).</u>**
DPT or Tdap_____ Polio_____ MMR_____ Hep B_____ Influenza_____
Other _____

For persons 18 or older: I verify that the health history provided above is true and correct to the best of my knowledge. 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 above.

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

----------FOR MEDICAL PRACTITIONER'S USE ONLY----------

I verify that the medical history the potential staff member named above has completed, is true and correct to the best of my knowledge. And that this person is in satisfactory physical condition, and capable of active participation in a regular camp program including the 5-mile or 11-mile intermediate hike except as follows:

_____ _____
Signature of Medical Practitioner **Date:**

Volunteer: If you are under the age of 18 you must have your parent fill out, sign, and date the form back of this form. <u>This is a requirement for acceptance as a camp volunteer.</u>

NAME OF PARENT OR GUARDIAN:

_____

PARENT ADDRESS_____

PARENT PHONE NUMBERS: _____

RESPONSIBLE PARENTS' EMPLOYER: _____

_____

EMPLOYER'S PHONE NUMBER (in case of an emergency and you are at work: _____

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)**