

Camp Love's Embrace  
Volunteer Health History Form

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First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

In case of emergency please notify: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ Day Phone: ( ) \_\_\_\_\_-\_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_-\_\_\_\_\_ Night Phone: ( ) \_\_\_\_\_-\_\_\_\_\_

**Health History (check those that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> AIDS                 | <input type="checkbox"/> Heart Disease      |
| <input type="checkbox"/> Allergies            | <input type="checkbox"/> Kidney Disease     |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Nosebleeds         |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Special Diet       |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Contacts           |
| <input type="checkbox"/> Fainting             | <input type="checkbox"/> Glasses            |
| <input type="checkbox"/> Hearing Impairment   | <input type="checkbox"/> Other              |

Please explain any "yes" answers to the above. Indicate any information useful to any of these health conditions.

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**IMMUNIZATIONS:**

Tetanus Shot: Year of last booster: \_\_\_\_\_

Date of your last health examination: \_\_\_\_\_

Were any complicating medical problems noted? \_\_\_Yes \_\_\_No

If yes, please explain: \_\_\_\_\_

Since your last health exam, have you had any of the following:

A serious injury requiring medical attention: \_\_\_Yes \_\_\_No

An illness lasting longer than one week: \_\_\_Yes \_\_\_No

A surgical operation or fracture: \_\_\_Yes \_\_\_No

Medication prescribed to be taken on a regular basis: \_\_\_Yes \_\_\_No

Inpatient or emergency room treatment in a hospital: \_\_\_Yes \_\_\_No

Please explain any "yes" answers to the above questions. Include dates

I know of no health reason(s) other than the information indicated on this form, why I should not participate in any of Camp Love's Embrace activities. \_\_\_\_\_ signature

### AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Should a medical emergency arise during my participation in a Camp Love's Embrace activity and I am unable to speak for myself, I consent to:

1. The administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below or chosen by the Camp director, and
2. The immediate administration of life-sustaining measures deemed necessary under the circumstances.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

### HEALTH INSURANCE INFORMATION:

Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_

Preferred Medical Doctor/Medical Facility/Phone Number: \_\_\_\_\_

### STATEMENT OF CONFIDENTIALITY

**I understand that information regarding Camp Love's Embrace campers, their families, staff, and any persons receiving support or services in any capacity is privileged information for the use by and with authorized person(s) only.**

**I will disclose such information only in the discharge of my assigned duties and responsibilities with Camp Love's Embrace or person(s) authorized to receive such information through the signed consent of patient, family member, or affected party.**

**I will not disclose any information with anyone unauthorized to receive this information. I will handle any and all paperwork and forms with proper procedure of control so that no information is accidentally observed or released to any unauthorized person(s). I also understand that the casual sharing of camper/camper families/ staff information in public places or settings is inappropriate.**

**I have read and understood the preceding Statement of Confidentiality and agree to abide by it.**

**Print Name: \_\_\_\_\_**

**Signature: \_\_\_\_\_**

**Date: \_\_\_\_/\_\_\_\_/\_\_\_\_**