Camp Love's Embrace
Volunteer Health History Form

First Name: _____ MI: ____
Last Name: _____

Address: _____ Apt#: ____
City: _____ State: _____ Zip: _____

Birthdate: ___/___/____ Age: _____ Sex: _____

In case of emergency please notify: _____
Address: _____
Relationship: _____ Day Phone: ( )____-_____
Cell Phone: ( )____-_____ Night Phone: ( )____-_____

Health History (check those that apply)

___AIDS
___Allergies
___Asthma
___Convulsions/Seizures
___Diabetes
___Epilepsy
___Fainting
___Hearing Impairment
___Heart Disease
___Kidney Disease
___Nosebleeds
___Sickle Cell Anemia
___Special Diet
___Contacts
___Glasses
___Other

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

_____
_____
_____

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

<u>AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT</u>

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:
_____

<u>STATEMENT OF CONFIDENTIALITY</u>

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: ____/____/____