

# Koinonia Conference Grounds 2012 Volunteer Health Form

**PLEASE SUBMIT A COPY OF YOUR IMMUNIZATION RECORDS WITH THIS FORM.**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age at Camp: \_\_\_\_\_

Gender:  Male  Female Camp Week – (check all that apply):  Water Sports  Kids  Jr High

The information provided on this form will be used to brief kitchen staff about your nutritional needs and educate the Camp Director and Healthcare Staff about your health background and needs. Receiving adequate information at least two weeks prior to your arrival is crucial to our ability to provide the proper supportive environment. Please read and complete this form thoroughly. **If you are under 18, please have your parents fill out this form and sign the consent and authorization for health care on the back of this form.**

**HEALTH HISTORY:** Please keep a copy for your records and to record changes in your health status. Please notify Koinonia Conference Grounds in writing if there are any changes before you arrive at camp.

**ALLERGIES:** Please mark those that apply.

I have no known allergies.

I have an allergy to the following: (List all foods, medications, and substances) \_\_\_\_\_

Does this cause anaphylaxis?  Yes  No  Unknown

Please describe allergic reaction (if any) and what steps are taken to manage it (attach additional information if needed): \_\_\_\_\_

**NUTRITION:** We are able to work with some medically prescribed diets but are unable to cater to individual food preferences. Please mark those that apply to you. Please call if you have any questions.

This camper eats a regular, varied diet

This camper is on a special diet

(Our expectation is that you will bring your own supply of products (such as Lactaid and gluten-free items) and will contact the camp nurse when the supplement is needed.)

**CHRONIC CONCERNS:** Please mark all that pertain to you and provide information about supportive health care.

I have no chronic health concerns and am capable of full participation in this program.

I have the following chronic health concern(s):

Asthma

Headaches

Sleepwalking

Diabetes

Hearing Difficulties

Menstrual Cramps

Frequent ear infections

Bedwetting

Bee Sting Allergy

Seizure Disorder

Surgical History

Fainting

Fears/Phobias

Other (please describe): \_\_\_\_\_

Please provide information about supportive health care needed for each marked item (if any): \_\_\_\_\_

If *Surgical History* is marked above, please explain: Date of Surgery: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Are all symptoms resolved?  Yes  No - Please explain: \_\_\_\_\_

Are you cleared by your physician for active camp participation?  Yes  No Date of last Tetanus shot: \_\_\_\_\_

Physician: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

Dentist: \_\_\_\_\_ Office Phone: (\_\_\_\_) \_\_\_\_\_

**MEDICATIONS:** All medications MUST be in original, pharmacy-provided containers and appropriately labeled. Please attach a note if the camper has been taking current dose for less than three months prior to arrival or if there are any changes.

This camper does not take any medication.

This camper takes daily medication:

1. Medication: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

Dose Taken: \_\_\_\_\_ How often each day? \_\_\_\_\_

2. Medication: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

Dose Taken: \_\_\_\_\_ How often each day? \_\_\_\_\_

3. Medication: \_\_\_\_\_ Reason for Taking: \_\_\_\_\_

Dose Taken: \_\_\_\_\_ How often each day? \_\_\_\_\_

**MEDICATIONS (continued): ALPHABETICAL!!!!**

The following medications, stocked in the Gauze Pad/Health Center, are used to manage illness or injury and dispensed as directed by our medical protocols. Generic form may be used. Please cross-out any medicine you **should not** be given:

|                         |                            |                            |                            |
|-------------------------|----------------------------|----------------------------|----------------------------|
| Acetaminophen (Tylenol) | Chamomile Tea              | Guaifenesin/DM (Cough Med) | Kaopectate/Anti-Diarrheals |
| Aloe                    | Cough Drops                | Hydrocortisone Cream       | Nix                        |
| Antacid                 | Decongestants              | Ibuprofen (Motrin)         | Tinactin                   |
| Bismuth liquid/tabs     | Diphenhydramine (Benadryl) | Insect Repellent           | Triple Antibiotic Cream    |
| Calamine Lotion         | Dramamine                  | Iodine Swabs               |                            |

**MENTAL, EMOTIONAL AND SOCIAL HEALTH:** Please mark YES or NO for each statement.

Please answer the following question:

Have you been diagnosed with ADD, depression, OCD, panic/anxiety disorder or had any other emotional, mental or social health concerns that continue to affect you or have prompted you to seek professional care? If so, please explain: \_\_\_\_\_

**BILLING INFORMATION FOR HEALTH CARE:** You are financially responsible for health care given by an out of camp provider. To whom should this provider route charges for your health care if the need arises? Please include a copy of an insurance card if appropriate. Please copy both sides of the card so addresses and telephone numbers are readable.

- I am not covered under an insurance policy.
- I am covered under the following health insurance:

Insurance Company: \_\_\_\_\_ Policy/Member #: \_\_\_\_\_

Insurance Company Telephone: (\_\_\_\_\_) \_\_\_\_\_ Name of Subscriber: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION:** We will call your emergency contacts in the event of an emergency or if we have questions about your health. Please provide contact information for other people who know you and with whom we can consult if you cannot respond to questions. We will assume you have spoken with these individuals and that they are willing to assist, should the need arise. Primary Contact: \_\_\_\_\_

Camper Lives With (name): \_\_\_\_\_ Daytime Telephone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Evening Telephone: (\_\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: (\_\_\_\_\_) \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to Camper: \_\_\_\_\_

**PARENT/GUARDIAN CONSENT AND AUTHORIZATION FOR HEALTH CARE (IF UNDER 18):** This health history is correct and the camper described has permission to participate in all activities, which may include the high ropes course, surfing, or mountain biking, except as noted by me and/or the examining physician. I will not hold Koinonia Conference Grounds or its agents liable for injury caused by common accident, illness, or the rendering of emergency care. I give permission for this child to participate in any offsite activities during camp and to be transported to and from any offsite activities, including emergency situations (if any) by authorized vehicles. Koinonia Conference Grounds has my permission to obtain a copy of my child's health record from the providers who treat my child. I understand that information about my child's health will be shared on a "need to know" basis with other Koinonia Conference Grounds staff. I give permission to the physician selected by Koinonia Conference Grounds to order X-rays, routine tests and treatment for the health of my child. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my child. This form may be photocopied. By signing below, I give permission to Koinonia Conference Grounds to use video or photography of me or my family members for promotional purposes.

**\*SIGNATURE OF CUSTODIAL PARENT/GUARDIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PERSONAL AUTHORIZATION FOR HEALTH CARE AND CONSENT:** This health history is correct and I am capable of participating in the full camp program at Koinonia Conference Grounds, which may include the high ropes course, surfing, and mountain biking, apart from the exceptions noted above. I will not hold Koinonia Conference Grounds or its agents liable for injury caused by common accident, illness, or the rendering of emergency care while I participate in the full camp program and the transport to and from offsite activities or an emergency situation (if any). Koinonia Conference Grounds has my permission to obtain a copy of my health record from my health providers. I understand that information about my health will be shared on a "need to know" basis with other Koinonia Conference Grounds staff. I give permission to the physician selected by Koinonia Conference Grounds to order X-rays, routine tests and treatment for my health in case of an emergency. If my emergency contacts cannot be reached, I give my permission to the physician selected by Koinonia Conference Grounds to hospitalize, secure proper treatment for, and order injection, anesthesia or surgery for my health. This form may be photocopied. I give permission to Koinonia Conference Grounds to use video or photography of me for promotional purposes.

**\*APPLICANT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_