Volunteer Health History Form

(provided for the camp physician)

Name ____

2011/2012 Address ______________________________

City ____________________________ State ________ Zip _____________

Phone # ______________________ Email address: ________________________

Date of Birth ______________________ Age _________ Sex _____________

Person to notify in case of an emergency __________________________________

Relationship ____

Address ____

Daytime Phone # ___________________ Evening Phone # __________________

Health History (please check those that apply)

____Allergies
____Asthma
____Seizures
____Diabetes
____Emotional Problems
____Hearing Impairment
____Physical limitations
____Motion sickness
____Wears contacts/glasses
____Heart Disease
____Other

Please explain any items that were checked or indicate any other useful information regarding your health or dietary needs.

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Are you currently under a physician's care for a medical problem? ________________

Are you restricted from participating in any physical activity?

I know of no health reasons, other than information indicated on this form, why I should not participate in any of the camp activities.

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Signature **Date**