# Adult Volunteer Staff Health History Record

***VOLUNTEER:****Please complete both sides of this form.*

***Mail this form to: Camp Arequipa P.O. Box 774 Fairfax, CA 94978- we need it at least 2 weeks before camp***

## PART I: PARTICIPANT RECORD

Name - Last, First,Middle Initial | Birth Date - MM/DD/YYYY | Age

Home Address | City/State/Zip

Day Time Telephone ( ) | Evening Phone ( ) | Cell Phone ( )

## PART II: EMERGENCY CONTACT

Name | Day Time Telephone ( ) | Evening Phone ( )

Home Address | City/State/Zip | Relationship to Volunteer

## PART III: HEALTH INSURANCE INFORMATION

Name of family PHYSICIAN: ______________________ Telephone: ( ) ______________________

Address of family PHYSICIAN: ______________________ City / State / Zip ______________________

Family Medical/Hospital INSURANCE CARRIER: ______________________ POLICY/GROUP NUMBER: ______________________

Do you have membership with a Health Maintenance Organization (HMO) such as Kaiser, Lifeguard, etc.? ❐Yes❐No

If yes, what ID number do you use? What is the HMO main phone number for emergencies? ( )

## PART IV: ALLERGIES/ILLNESSES/INJURIES

**Allergic Reaction:** (Check those that apply and specify nature of allergic reaction) **❐ Check here for no known allergies**

❐Animals ________ ❐Hay Fever ________ ❐Medicines/Drugs ________

❐Pollen ________ ❐Food ________ ❐Insect Stings ________

❐Plants/Poison Oak ________ ❐Other (specify) ________

**Chronic or Recurring Illnesses:** (Check those that apply and give appropriate dates)

❐Asthma ________ ❐Diabetes ________ ❐ Heart Defect/Disease ________

❐Musculoskeletal Disorder ________ ❐Bleeding/Clotting Disorders ________ ❐Ear Infection ________

❐Hypertension ________ ❐Seizures/Convulsions ________ ❐ Mononucleosis ________

❐ Skin Disease/MRSA ________ ❐Other (specify) ________

**Childhood Diseases:** (Check those that apply and give appropriate dates)

❐ Chicken Pox ________ ❐ Measles ________ ❐ German Measles ________

❐Mumps ________ ❐Other (specify) ________

**Other Health Conditions:** (Check those that apply)

❐Attention Deficit Disorder (ADD) ❐Down's Syndrome ❐Hearing Impairment ❐Nose Bleeds

❐Wears Glasses/Contacts ❐Bed Wetting ❐Emotional Disturbances ❐Menstrual Cramps

❐Sickle Cell Trait/Disease ❐Special Dietary Regimen ❐Dental Braces ❐Fainting

❐Motion Sickness ❐Sleep Disturbances ❐Visual Impairment ❐Autism Spectrum

**List any current physical, mental or psychological health conditionsrequiring medical treatment, special restrictions or considerations:** ________

**List any dietary restrictions or special considerations:** ________

**List any previous medical treatments, operations or serious injuries, provide dates:** ________

## PART V: MEDICATION

Over-the-counter medicines will be used to treat routine illness per Treatment Protocols. (Acetaminophen is used in place of aspirin.) Please list any over-the-counter medicines you **DO NOT** want you or your child to receive: ________

Do you take any medications? ❐ NO ❐ YES

*If YES, list medication, dosage, and possible side effects.*

| MEDICATION | DOSAGE | POSSIBLE SIDE EFFECTS |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**NOTE: We cannot administer medication that is not in its original container, labeled by the pharmacy with the name, address, dosage and frequency. Please label with name and dosage any over-the-counter drugs - anti-histamines, vitamins, etc.**

| PART VI: IMMUNIZATION HISTORY – REQUIRED I am providing a list of all medical immunization with the health history form OR I attest that all immunizations are current (please write Up-to-Date across chart below.) | | |
|---|---|---|
| **Vaccines** | **Date: Month / Year** | **Date: Month /Year** |
| Diptheria, Tetanus and Pertussis- DTP, DTaP or any combination of DTP or DTaP with DT (tetanus and diphtheria) | | |
| | | |
| Tdap Booster | | |
| Oral Polio (Sabin)* TOPV | | |
| Injectable Polio (Salk) | | |
| Measles, Mumps, Rubella (MMR) | | |
| Varicella | | |
| Hepatitis B | | |
| Tuberculin test given | | |
| Other: | | |

**List any condition that would limit full activity and in what way:**______________________________

______________________________

______________________________

**Additional comments:**______________________________

______________________________

______________________________

**PART VII: TREATMENT CONSENT**

This health history is correct as far as I know, and I can engage in all camp activities, except as noted by me or my physician. I am in good health. I give permission to receive treatment for routine medical and/or first aid needs, as outlined in the Treatment Protocols and for the administration of prescribed medications. In the event I cannot give my permission myself, I give permission to receive emergency medical and surgical treatment and to be hospitalized, if necessary. It is understood every effort will be made to reach the emergency contact noted above, before taking this action.

*All medications being taken are listed on the front of this form.

______________________________

**Signature of Volunteer** **Date**

## TRANSPORTATION TO/FROM CAMP:

I understand that I will be responsible to provide transportation to/from camp for myself and my own children daily, unless I am the Camp Arequipa Bus Rider. I will not transport other campers/children/aides, etc. to/from camp without the express permission of the Camp Arequipa Administrator. I understand that camp insurance does not cover transportation of campers/children/aides in my vehicle.

______________________________

**Signature of Volunteer** **Date**

## PHOTO PERMISSIONS:

We take unit photos at camp which we send home with each participant at the end of camp. In addition, many adult volunteers at camp enjoy taking photos throughout the week, and often share them with one another and with others from camp. We occasionally update our website with new photos from camp, especially those of our adult volunteers and their children. I understand that I may not publicly post photos of Arequipa campers on social media unless the photos are only of my own family members, or adult friends who have given me permission to do so.

I authorize Camp Arequipa to take photos of me as listed above.

______________________________

**Signature of Volunteer** **Date**

______ **I am a currently registered Girl Scout Adult**

______ **I am a lifetime Girl Scout member**

______ **I have completed the required Background Check Screening**