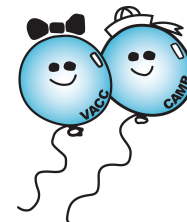


VACC CAMP HEALTH FORM



Please fill out this form as completely as possible.

Name: _____

Date Of Birth: _____

Address: _____

City: _____

State: _____

Zip Code: _____

HAVE YOU HAD ANY OF THE FOLLOWING?	YES	NO	UNKNOWN	IMMUNIZED FOR
CHICKEN POX				
RUBELLA (GERMAN MEASLES)				
MEASLES (SEVEN DAY)				

HAVE YOU EVER HAD A TUBERCULOSIS TEST? YES NO
 WAS THE RESULT? POSITIVE: NEGATIVE:

Do you have or are you being treated for?:

<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Immune Deficiency
<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	Skin Disorders/Rashes
<input type="checkbox"/>	Diabetic on Insulin	<input type="checkbox"/>	Partial Blindness
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Wrist, Back or Neck Injury

List all medications you are taking: _____

Describe any physical limitation (s) you have that staff should be aware of to help you participate fully as a camp volunteer: _____

Physician: Name: _____

Phone: _____

I authorize emergency treatment for myself if I am injured or taken ill during my service at camp if I am not able to give consent for my treatment and the staff is unable to reach my emergency contact .

SIGNATURE: _____ DATE: _____

Parental Consent for Teen Volunteers (Under 18 years of age): I hereby consent to the participation of my daughter/son _____ as a camp volunteer. I authorize the emergency treatment of my daughter/son if s/he is injured or taken ill during volunteer service at camp if staff is not able to contact me for permission to treat.

SIGNATURE OF PARENT: _____ DATE: _____