Nicklaus Children's Hospital | 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?:

☐	Allergies	☐	Hearing Problems
☐	Asthma	☐	Immune Deficiency
☐	Chronic Cough	☐	Skin Disorders/Rashes
☐	Diabetic on Insulin	☐	Partial Blindness
☐	Epilepsy	☐	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: _____