CAMP GOOD NEWS VOLUNTEER MEDICAL FORM

LAST NAME _____ FIRST NAME _____

❑ MALE ❑ FEMALE AGE _____ DATE OF BIRTH _____

FATHER'S NAME _____ CELL/WORK PHONE _____

MOTHER'S NAME _____ CELL/WORK PHONE _____

IN CASE OF EMERGENCY CALL: NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____

IMMUNIZATIONS:
DIPHTHERIA, MEASLES, MUMPS, POLIO, RUBELLA, WHOOPING COUGH ARE CURRENT:
❑ YES ❑ NO

TETANUS: LAST BOOSTER WAS IN (DATE) _____

DIFFICULTIES: *(CHECK THOSE YOU HAVE)* ❑ HEADACHES ❑ DIABETES ❑ KIDNEY TROUBLE
❑ NOSEBLEEDS ❑ HEART TROUBLE ❑ ASTHMA 0R WHEEZING ❑ SKIN RASHES
❑ BOWEL PROBLEMS ❑ FREQUENT COLDS ❑ SORE THROATS ❑ EAR ACHES
❑ MENSTRUAL DIFFICULTIES

EXPLANATIONS:

_____

ALLERGIES (SKIN, RESPIRATORY, FOOD, MEDICATION):

_____

MEDICATIONS: (PRESCRIPTIONS/OVER-COUNTER), DOSAGES & ROUTINE:

_____

SPECIAL HEALTH CONSIDERATIONS: (DIET, TREATMENT, OTHER):

_____

DISABILITIES (HEARING, VISION, WALKING ETC):

_____

FAMILY INSURANCE COMPANY _____
POLICY/GROUP/CONTRACT# _____

GOOD NEWS CLUB, INC. OF NORTHUMBERALND COUNTY CLARIFICATION: STAFF AND CAMPERS PERSONAL HEALTH INSURANCE IS PRIMARY, CAMP INSURANCE IS EXCESS. THE HEALTH HISTORY IS CORRECT AS FAR AS I KNOW, AND THE PERSON HEREIN HAS MY PERMISSION TO ENGAGE IN ALL CAMP ACTIVITIES, EXCEPT AS NOTED BY ME AND/OR ATTENDING PHYSICIAN. IN CASE OF MEDICAL OR SURGICAL EMERGENCY, I GIVE MY PERMISSION FOR A PHYSICIAN TO GIVE PROPER EMERGENCY TREATMENT FOR THE STAFF MEMBER NAMED ABOVE. WHILE AT CAMP GOOD NEWS, I AUTHORIZE THE CAMP NURSE TO ADMINISTER MEDICATIONS AND TREATMENTS FOR THE PERSONS NAMED ABOVE. I GIVE MY PERMISSION FOR ABOVE APPLICANT TO BE INCLUDED IN ANY PHOTOGRAPHS, VIDEO, AND/OR WEB SITE PUBLICATION.

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____
or applicant, if age 18 or older