



# VOLUNTEER HEALTH & REGISTRATION FORM

*THIS FORM MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN  
AND NOTARIZED IF THE COUNSELOR IS UNDER 18 YEARS OF AGE.*

## VOLUNTEER COUNSELOR INFORMATION

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ INITIAL \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Initial \_\_\_\_\_

Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Telephone \_\_\_\_\_

Spouse Name \_\_\_\_\_ Bus. Telephone \_\_\_\_\_

## IF PARENT/GUARDIAN IS NOT AVAILABLE IN EMERGENCY, NOTIFY

Emergency Contact \_\_\_\_\_ Telephone \_\_\_\_\_

Relationship to Volunteer \_\_\_\_\_

## CONSENT RELEASE

In signing this release, I certify that the information provided on this form is correct. In case of a medical emergency, I authorize the release of medical records and understand that every effort will be made to contact the parent/guardian. In the event that the parent/guardian cannot be reached, permission is hereby given to the physician selected by The Warwick Center to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for myself (son/daughter), as named herein. I authorize the Camp Warwick Health Director to supervise the self-medication of prescription and over-the-counter medicines by myself (son/daughter) at on-site camps and supervise the First Aid personnel of off-site camps in the distribution of medicines. I give permission for myself (son/daughter) to be transported in The Warwick Center vehicles or other designated vehicles to and from public transportation. I give permission for myself (son/daughter) to be transported by public transportation as necessary for approved off-site camp activities. I authorize the use of photographs of myself (son/daughter) in camp publicity.

### AUTHORIZED SIGNATURE REQUIRED:

\_\_\_\_\_  
*Counselor (OR Parent/Guardian Signature, if counselor is under 18)*

\_\_\_\_\_  
Date

### NOTARY PUBLIC STAMP

\_\_\_\_\_  
*Notary Public Signature*

\_\_\_\_\_  
Date

**(COMPLETE HEALTH INFORMATION ON REVERSE SIDE)**

# VOLUNTEER COUNSELOR HEALTH INFORMATION

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_  Male  Female

Date of Last Physical Exam \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician/Clinic \_\_\_\_\_ Telephone \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Health Insurance Co. Phone # \_\_\_\_\_ *Please attach copy of insurance card (front & back)*

Prescription drug policy?  Yes  No *If yes, attach a photocopy of the card (front and back).*

## IMMUNIZATION RECORD *(List dates - NYS requirement)*

D.P.T. \_\_\_\_\_ M.M.R. \_\_\_\_\_  
Oral Polio Vaccine \_\_\_\_\_ OPV Booster \_\_\_\_\_  
Hepatitis B \_\_\_\_\_  
Tetanus Booster \_\_\_\_\_  
T.B. Test: \_\_\_\_\_  Positive  Negative

*TB TEST MUST BE ADMINISTERED WITHIN THE PAST YEAR.*

## ALLERGIES

Asthma  Yes  No Sulpha  Yes  No  
Bee Sting  Yes  No Suntan Lotion  Yes  No  
Hay Fever  Yes  No Poison Ivy/Oak/  Yes  No  
Penicillin  Yes  No Sumac  Yes  No

Other: \_\_\_\_\_

## FOOD & SKIN SENSITIVITIES *(Please list)*

\_\_\_\_\_  
\_\_\_\_\_

## MEDICATIONS

*I give permission to the Camp Warwick Health Director to supervise and/or administer the following medications (check off):*

\_\_\_\_\_ Antacids \_\_\_\_\_ Tylenol  
\_\_\_\_\_ Aspirin \_\_\_\_\_ Other over-the-counter  
\_\_\_\_\_ Cold Medications \_\_\_\_\_ medications (list):  
\_\_\_\_\_ Cough Syrup \_\_\_\_\_  
\_\_\_\_\_ External Ointments \_\_\_\_\_  
\_\_\_\_\_ Suntan Lotion \_\_\_\_\_

## MEDICAL INFORMATION

Are you in general good health and able to participate in all normal camp activities?  Yes  No

If no, please explain on a separate sheet of paper.

ADD  Yes  No Heart Murmur  Yes  No

ADHD  Yes  No Homesickness  Yes  No

Ear Infections  Yes  No Hyperactive  Yes  No

Diabetic  Yes  No Special Diet  Yes  No

Seizure Disorders  Yes  No

*List any of the following:*

Chronic-recurring illness \_\_\_\_\_

Convulsive disorders \_\_\_\_\_

Recent illness/injury \_\_\_\_\_

Contagious diseases \_\_\_\_\_

*Please submit statement of how you have been treated and with what medication.*

Serious operations *(list date/type):* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all prescription medications you are currently taking. Include the dosage & instructions for use.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The HEALTH DIRECTOR will supervise the self-medication of prescription and over-the-counter medicines by counselors at on-site camps and supervise the First Aid personnel while off-site in the distribution of medicine. The Health Director stocks most common medications such as Tylenol and cold remedies, so it is not necessary to bring them to camp. **ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE IN THE ORIGINAL CONTAINER, LABELED WITH THE COUNSELOR'S NAME AND WRITTEN INSTRUCTIONS SIGNED BY YOUR PHYSICIAN ATTACHED. ALL MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER) MUST BE GIVEN TO THE HEALTH DIRECTOR**

**PLEASE KEEP A COPY OF THIS FORM FOR FUTURE REFERENCE.**

VOLUNTEER HEALTH & REGISTRATION FORM 2011