Staff/Volunteer Medical Release

This Form Must Be Sent in Prior to Your First Day or Brought with You on Your First Day

Adult Summer Employees/Volunteers (18 and older): complete form and sign.
Minor Summer Employees (under 18 years of age): Parent/Guardian must complete form and sign.

Personal Information

Name of Staff/Volunteer: (Last) _____ (First) _____ (MI) _____

Home Phone: _____ D.O.B._____ Age: _____ Gender: _____

Parent/Guardian Name: (Last) _____ (First) _____

Address: _____City/State: _____ Zip: _____

1st Emergency Contact: _____ Ph #: _____

2nd Emergency Contact: _____ Ph #: _____

Physician Name: _____ Ph #: _____

Is the participant covered by family medical hospital insurance? ☐YES ☐NO

If yes, please indicate carrier _____ Policy or Group #: _____

Please provide a copy of the front and back of the health insurance card and attach to this form.

Health History

Immunization Records

Please Note: A current immunization record from doctor must be provided before a staff member will be allowed to start employment. Please attach to this form.

Date of last Tetanus shot: _____ Are immunizations current? ☐YES ☐NO

If No, which one(s) are not current? _____

Medications

Able to take Tylenol? ☐YES ☐NO Able to take Advil? ☐YES ☐NO

Are you currently on any medication? Please specify: _____

Please list Medications that you are bringing to camp: ***(All medications must be kept in the nurse's station)***

Medication_____ Dosage_____ x Daily _____ Time_____

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Prescribing Physician (s) _____

Allergies: *Check those that apply to you.*

☐ I have no known allergies.

☐ I have an allergy to this food: _____ This causes anaphylaxis? ☐YES ☐NO

☐ I am allergic to this medication(s): _____ This causes anaphylaxis? ☐YES ☐NO

☐ I am allergic to these substances:

☐Bee Stings ☐Poison Ivy/Oak (Highly Allergic) ☐Other _____

This causes anaphylaxis? ☐YES ☐NO

Describe what happens if you eat this **food** or are exposed to these **medications** or **substances** and how the reaction is managed:

_____

_____

Nutrition: *Our expectation is that staff set an example for campers by eating the provided meal. We work with some medically prescribed diets, such as gluten-free and lactose intolerance. Please contact our Food Service Director, Ellie Davis (ellie@pinesprings.org), prior to the summer to discuss any concerns.*

☐ I eat a regular, varied diet and am prepared to eat a variety of foods while at camp.

☐ I have the following dietary restrictions:

☐ Gluten intolerance ☐ Peanut and/or tree nut free ☐ Celiac disease

☐ Vegetarian (please give any additional details below) ☐ Lactose intolerance

☐ Vegan (please give any additional details below) ☐ Other: _____

Describe any additional information our Food Service Coordinator should be aware of: _____

_____

Chronic Concerns: *Check all that pertain to you and provide information about supportive healthcare. Completion of this section is voluntary, yet helpful to healthcare staff.*

☐ I have no chronic health concerns.

☐ I have the following chronic health concern(s):

☐ Asthma ☐ Headaches, Migraines ☐ Surgical History

☐ Diabetes ☐ Difficulty breathing ☐ Severe PMS symptoms

☐ Fainting ☐ Back pain or injury ☐ Seizure disorder: _____

☐ Sleep Problems ☐ Knee or ankle weakness ☐ Other: _____

Have you had any illnesses, injuries, or surgeries? _____

_____

Any special medical conditions you may have that would require extra care? _____

_____

Any special restrictions or considerations while at camp? _____

_____

Have you had a recent exposure to a contagious or infectious disease? _____

_____

Any physical, emotional or mental concerns we should be aware of, such as health habits, health conditions, menstruation, recent loss or trauma? _____

_____

IMPORTANT: This section must be completed for participation in camp activities

Parent/Guardian OR Staff Member/Volunteer Authorization: This health history is correct and complete as far as I know. The person herein described has permission to engage in all camp activities except as noted. I hereby give permission to the camp's health care provider to provide routine health care; to administer medication; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician or dentist selected by the camp to secure and administer treatment, including hospitalization, for the person named above. I affirm that the camp, its staff and volunteers are held harmless from any liability claims, judgments, and costs incurred during my/my child's stay at the facility or involvement in the camp experience. This completed form may be photocopied for trips out of camp.

_____

Employee/Volunteer Printed Name (OR Parent/Guardian Printed Name for Employees under 18)

_____ _____

Employee/Volunteer Signature (OR Parent/Guardian Signature for Employees under 18) *Date*