

VOLUNTEER MEDICAL FORM

Senior Counselor _____ Assistant Counselor _____ Position _____
Nurse _____ Dean _____ Other _____ Site _____
Event Dean _____ Employment Dates _____
Camp Site/Dates _____

Name _____ Home Phone (____) _____
Address _____
City _____ State _____ Zip _____
E-mail _____ T-Shirt Size _____
Local Church _____ District _____
Pastor's Name _____ Phone (____) _____

MEDICAL INFORMATION

Birth Date ____/____/____ Age ____ Male ____ Female ____
Height ____ Weight ____ Allergies _____
1. List any medical problems or restrictions _____

2. List medication you are currently taking _____
3. Have you had a tetanus injection within the past 5 years? Yes ____ No ____
4. Date of last physical examination within the past 24 months _____
Health Insurance Company _____
ID/Policy # _____ Group # _____
Primary Care Physician _____ Phone (____) _____
Emergency Contact: Name _____ Phone (____) _____

(Signature if 18 years of age or older)

_____/_____/_____
(Date)

IF AGE 17 OR YOUNGER

Your parent/guardian's signature is required below before you are permitted to take part in the camping program.

Parent's / Guardian's Name(s) _____

Address _____

City _____ State _____ Zip _____

Email Address: _____

Father's Employer _____ Work Phone (____) _____

Cell Number (____) _____

Mother's Employer _____ Work Phone (____) _____

Cell Number (____) _____

Emergency Contact: Name _____ Phone (____) _____

Cell Number (____) _____

Address _____

City _____ State _____ Zip _____

Parent's / Guardian's Signature _____ Date ____/____/____