ANCHOR OFFICE USE ONLY: GROUP: _____

BUS: _____

CAMP ANCHOR VOLUNTEER MEDICAL FORM

PLEASE COMPLETE THE FRONT OF THIS FORM AND ATTACH A PHYSICAL SIGNED BY YOUR DOCTOR OR HAVE YOUR DOCTOR COMPLETE THE BACK PORTION. PHYSICALS MUST BE WITHIN THE LAST 18 MONTHS.

LAST NAME _____ FIRST NAME _____

ADDRESS _____

TOWN _____ STATE _____ ZIP CODE _____

_____ _____

FATHER'S NAME- BUSINESS PHONE # MOTHER'S NAME – BUSINESS PHONE #

_____ _____

FATHER'S CELL PHONE # MOTHER'S CELL PHONE #

_____ _____

PHYSICIAN TO BE CALLED IN EMERGENCY PHYSICIAN'S PHONE #

_____

NAME AND PHONE # OF EMERGENCY CONTACT PERSON (if parents cannot be reached)

IF ANY MEDICATION, INHALER, OR EPI-PEN IS TAKEN OR USED AT THE CAMP, THE DOCTOR'S ORDERS MUST BE COMPLETED ON THE BACK OF THIS FORM.

Please be aware:

- Volunteers **cannot** carry **any** medication during the camp day. All medication must be left with the camp nurse.
- Volunteers **cannot** volunteer if an injury requires the wearing of a cast, brace, or boot.

DUE BY: MAY 1, 2024

HEALTH HISTORY

Immunizations Dates – REQUIRED FOR ALL VOLUNTEERS

Height _____ Weight _____ Blood Pressure _____

DPT (or DT) _____ / _____ / _____ / _____

Hep B _____ / _____ / _____ HIB _____ / _____ / _____

Chicken Pox _____ / _____ MMR _____ / _____ (2 measles required)

Polio (TOPV) _____ / _____ / _____ / _____ Menactra _____ / _____

IF THERE IS BLOOD WORK WITH TITERS – PLEASE SUBMIT YEARLY

Does Volunteer have heart problems? _____Yes _____No

If yes, specify_____

Specify any significant illness, injury, or surgery: _____

_____

Does Volunteer have asthma? _____Yes _____No

If yes, does he/she use an inhaler? _____Yes _____No

Does Volunteer have any allergies? _____Yes _____No; specify _____

If yes, What type of reaction? _____ Epi Pen? _____Yes _____No

Does Volunteer take any medications regularly? _____Yes _____No; specify _____

_____

All daily medication and/or emergency / prn medications require physician's orders and parent's written permission (including Tylenol/Ibuprofen).

Doctor's Order: _____

_____

Please attach volunteer's photo ID to the box of medication, Epi-Pen and/or inhaler

I certify this patient is in good health and qualified to volunteer with no restrictions on activities.

_____ _____

Signature of Physician Date

_____ Physician's Stamp

Print Physician's Name