# HEALTH HISTORY FORM FOR WEKIVA YOUTH CAMP VOLUNTEERS

Name: ______________________________________________________________________________
First Middle Last

Sex: ☐ Female ☐ Male Birthdate: ___________________________________________________

Permanent Address: ___________________________________________________________
Street Address

___________________________________________________________
City State/Country Zip/Code

E-mail: ______________________________ Preferred Phone Number: (______)________________________

Is this your first year as a Volunteer? . . . . . . . . . . ☐ No ☐ Yes

- *Return this form to the Chairman indicated on the Volunteer Application at least four weeks prior to your arrival.*
  *If within four weeks of your start date do not send this form; bring it with you and give it to the Chairman at camp.*
- *Keep a copy of this form for your records.*
- *Notify the Chairman if you are exposed to a communicable disease within three weeks of your arrival OR if any changes have occurred.*
- *The camp expects that you arrive in good health and capable of performing the essential functions of your position.*
  *If you have concerns regarding this, speak with the Chairman prior to arrival.*
- *Information on this form is available to Health Center staff and the Chairman, as necessary.*

## Allergies: *Check those that apply to you.*

_____ I have no known allergies.

_____ I have an allergy to this food: ________________________________ This causes anaphylaxis? ☐ Yes ☐ No

Describe what happens if you eat this food and how the reaction is managed:

__________________________________________________________________________

__________________________________________________________________________

_____ I am allergic to this medication(s): ____________________________ This causes anaphylaxis? ☐ Yes ☐ No

_____ I am allergic to these substances: ____________________________ This causes anaphylaxis? ☐ Yes ☐No

Describe what happens if you 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 can work effectively with some medically prescribed diets, but cannot cater to individual preferences. There are times when you might need to simply not eat a served item.*

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

_____ I am a vegetarian of this type:

☐ Semi-vegetarian (no pork or beef) ☐ Ovo (no meats, fish, seafood, or dairy)
☐ Pesco (no pork, beef, or chicken) ☐ Lacto-ovo (no beef, pork, chicken, seafood, or fish)
☐ Lacto (no meats, fish, seafood, or eggs) ☐ Vegan (no meats, seafood, eggs, or dairy)

_____ I am lactose-intolerant. *Be prepared to manage your intolerance using products such as Lactaid or food avoidance.*

_____ I do not eat _______________ products because of religious beliefs.

_____ I respond with an anaphylactic reaction when I eat this food: ______________________________

## Chronic Concerns: *Check all that pertain to you and provide information about supportive healthcare.*

_____ I have no chronic health concerns.

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

☐ Asthma * ☐ Headaches, Migraines ☐ Sleep problem
☐ Diabetes * ☐ Difficulty breathing ☐ Dysmenorrhea
☐ Fainting ☐ Surgical history ☐ Seizure disorder: ____________________
☐ Back pain or injury ☐ Knee or ankle weakness ☐ Other: ______________________________

* Insert additional information regarding Asthma or Diabetes including how the condition is managed or will impact your time with us: ________________________________________________

Provide information about supportive healthcare needed for each checked item: ______________________________
________________________________________________________________________

## Immunization History:

Date (month/year) of your most recent tetanus immunization: ______________________________

Provide the month & year for all immunizations:

Meningitis ____________________

Hepatitis B____________________

Influenza______________________

Polio__________________________

Varicella (Chicken Pox) ____________________

MMR (Mumps, Measles, Rubella)____________________

Pneumococcal______________________________

DPT (Diptheria, Tetanus, Pertussis)____________________

Hepatitis A______________________________

## Medication:

*Bring enough medication to last or bring your written prescription to order a refill. Prescriptions meds MUST be in pharmacy containers with appropriate labels; other remedies must be in original container.*

_____ I do not take medication on a routine basis.

_____ I take routine medication (including vitamins) as noted (Name of Medication; Reason for Taking It; Dose Given & When:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

## General Physical History:

*If you answer "Yes" to any of these questions, provide more information at the end of this section. Completing this session is voluntary, but helpful to healthcare staff.*

1. Have you ever been hospitalized? . . . . . . . . . . ☐ Yes ☐ No
2. Have you ever had surgery? . . . . . . . . . . ☐ Yes ☐ No
3. Have you ever passed out during or after exercise? . . . . . . . . . . ☐ Yes ☐ No
4. Have you ever been dizzy during or after exercise? . . . . . . . . . . ☐ Yes ☐ No
5. Have you ever had chest pain during or after exercise? . . . . . . . . . . ☐ Yes ☐ No
6. Do you tire more quickly than your friends during exercise? . . . . . . . . . . ☐ Yes ☐ No
7. Have you ever had high blood pressure? . . . . . . . . . . ☐ Yes ☐ No
8. Have you ever been told that you had a heart murmur? . . . . . . . . . . ☐ Yes ☐ No
9. Have you ever had a racing heartbeat or skipped heartbeats? . . . . . . . . . . ☐ Yes ☐ No
10. Have you ever been knocked out or become unconscious? . . . . . . . . . . ☐ Yes ☐ No
11. Have you ever had a seizure? . . . . . . . . . . ☐ Yes ☐ No
12. Have you ever had a stinger, burner, or pinched nerve? . . . . . . . . . . ☐ Yes ☐ No
13. Have you ever had heat or muscle cramps? . . . . . . . . . . ☐ Yes ☐ No
14. Have you ever been dizzy or passed out in the heat? . . . . . . . . . . ☐ Yes ☐ No
15. Have you ever sprained, strained, dislocated, fractured, broken or had repeated swelling, or other injuries to any of your body areas? . . . . . . . . . . ☐ Yes ☐ No

    If so, where? ☐ Head ☐ Shoulder ☐ Leg ☐ Neck ☐ Chest
    ☐ Arm, hand ☐ Ankle ☐ Back ☐ Hip ☐ Foot

16. Have you had mononucleosis in the past nine months? . . . . . . . . . . ☐ Yes ☐ No
17. Do you have an uncorrected hearing problem? . . . . . . . . . . ☐ Yes ☐ No

18. Do you have an uncorrected vision (sight) problem? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No
19. Do you wear glasses or contacts or use protective eye wear? . . . . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No
20. Do you wear hearing aids? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No
21. Do you smoke and/or use other tobacco products? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No
22. Do you have any problems with your teeth? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ☐ Yes ☐ No
23. Have you been in countries other than the United States in the past nine months? . . . . . . . . ☐ Yes ☐ No

If yes, list the countries and the time spent in them.

Country: ______________________________ Dates: ____________________

Country: ______________________________ Dates: ____________________

Country: ______________________________ Dates: ____________________

Use the space below to explain and/or provide more detail about the General Physical Health questions to which you responded "Yes."

# ______ ______________________________________________________________

# ______ ______________________________________________________________

# ______ ______________________________________________________________

# ______ ______________________________________________________________

Name of your physician: ______________________________ Office Phone (_________)______________________

Name of your dentist/orthodontist: ______________________________ Office Phone (_________)______________________

## Paying for Health Care

- There is usually no charge for healthcare provided by the camp's Health Center staff.
- You are financially responsible for healthcare provided by all other providers.
- If you will be using personal insurance while working at camp, know how to access that insurance. Bring your insurance card and know how to use it. Consider obtaining pre-authorization if your insurance requires this.

**PLEASE SEND A COPY OF YOUR INSURANCE CARD (Front & Back) WITH YOUR PAPERWORK.**
**If you do not have Health Insurance, please submit a Notarized Statement of Responsibility.**

## Emergency Contact: *Who do you want us to contact in an emergency?*

First Contact: ______________________________ Preferred Phone: (______)_______________ Relationship to You: _______________

Alternate Contact: ______________________________ Preferred Phone: (______)_______________ Relationship to You: _______________

## Authorization for Healthcare:

This health history is correct. I am capable of performing the essential functions of my job and participating in assigned work duties as noted on this form. I understand my health information will be used by the camp's Health Center staff in providing care to me and may be reviewed by my work supervisor(s).

*Signature of Volunteer:* ______________________________________ *Date:* ______________________

## Volunteer STOP Here.

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Date/Time **Documentation by Health Center Staff Use** Initial

EXIT NOTE:

☐ Left camp this day with the following problem/concern: ______________________________________

Summary of nursing instructions provided: ______________________________________

Exit note completed by: ______________________________

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