



2010 CAMP CHOSÔN STAFF AND VOLUNTEER HEALTH FORM

This form is necessary to provide a safe environment for all and comply with the medico-legal policies inherent to organizations such as ours. Please complete and return to our Medical Director post-marked by 5/31. **A completed form is required for volunteers and staff under the age of eighteen and/or anyone staying overnight at camp.** One individual should be listed per form. All information is confidential and will be handled appropriately. Incomplete forms will be returned, and registration will be considered incomplete if one does not have a form on file with us. **Send your completed form to: Camp Chosôn Medical Director, 12 Lost Rock Lane, North Oaks, MN 55127; or e-mail to ferickson@comcast.net.**

Staff/Volunteer Information:

Name: Last, First, Middle

Alias, Maiden or Nickname

Birth Date

Age

Gender

E-Mail Address

Street Address

City

State

Zip

(_____) _____
Work Phone

(_____) _____
Cell Phone

(_____) _____
Additional Phone

Emergency Contact Information:

Next-of-kin and their relationship

(_____) _____
Home Phone

(_____) _____
Work Phone

(_____) _____
Cell Phone

(_____) _____
Additional Phone

Other than Next-of-kin above, list another Adult as a secondary contact and their Relationship

(_____) _____
Home/Work/Cell Phone

Health History Information:

CURRENT MEDICAL ILLNESSES OR DIAGNOSES (Circle all that apply and list any others):

Diabetes

Emotional/Behavioral Disorder

Immunosuppression (specify)

Seizure Disorder

Bleeding/Clotting Disorder

List any Others (include surgeries):

Asthma/COPD

Strokes/CVA

Heart disease

Glasses/Contacts

Skin Condition

Disability (specify)

Date of last Tetanus Immunization: _____

If under age 18, All Immunizations Up to Date: Y or N

ALLERGIES (Please list all that apply, or check the appropriate box):

Medication Allergies (None Known): _____

Insect Sting/Bite Allergies (None Known): _____

Food Allergies (None Known): _____

Other Allergies (None Known): _____

Please Describe the severity of the allergic reaction and how it is managed:

MEDICATIONS I do not take any medication on a routine basis.

(Please list all medications you take, including vitamins or over-the-counter medications. Each Volunteer is responsible for their own medications at camp. Common nonprescription medications will be available from First Aid at camp.)

<u>Name of Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Reason taking Medication</u>
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Provider Information:

<hr/> <i>Name of Personal Physician and Clinic</i>	(_____)_____ <i>Phone</i>
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<hr/> <i>Name of Personal Dentist/Orthodontist and Clinic</i>	(_____)_____ <i>Phone</i>
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Health Insurance:

All Volunteers are financially responsible for health care given by an out-of-camp provider should one be necessary.

<hr/> <i>Name of Insurance Provider/Company</i>	<hr/> <i>Policy/Group Number</i>	<hr/> <i>Identification Number</i>
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Physician Statement:

The individual named on this form must have had a physical examination within 24 months prior to camp to determine physical fitness and be able to participate. By signing this, the physician verifies that: he/she is a licensed physician; the individual named above has had a physical exam more recently than 6/30/08; the record of the exam is on file at the physician's office/clinic; the individual is physically and emotionally able to participate in routine summer camp activities (please note any exceptions below); the individual's immunizations are up to date; and, the Health History Information listed above is accurate.

Please list date of last exam, any exceptions to the above statement, and any restrictions of activity: _____
Date of Last Exam

<hr/> <i>Physician Name - Please Print</i>	<hr/> <i>Signature</i>	<hr/> <i>Date Signed</i>
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AUTHORIZATION: To the best of my knowledge the information contained on this form is correct. I will assume the inherent risk associated with participation in all camp activities except as otherwise noted on this form. I give permission to the Girl Scout Council of St. Croix Valley (GSCSCV) personnel, or designated volunteers of Camp Chosôn, to provide treatment and medications for me, including administration of the medications listed above, in accordance to the information contained within. In the event of an emergency when next-of-kin cannot be reached, I give permission to the physician selected by GSCSCV personnel or designated volunteers of Camp Chosôn, to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery on my behalf. I agree to hold harmless the Girl Scout Council of St. Croix Valley, the St. Croix Valley Korean-American Cultural Society, staff, counselors and other designated volunteers from any and all losses and/or accidents, however caused, and agree to release all parties involved from claim or damage that may arise as a result of such loss or accident.

Unless this box is checked, I acknowledge that I may be included in photographs taken during camp when normally participating in activities, classes or any other part of camp life, and **give my permission** for such photographs to be used (without identifying information included) in promotional material created by Camp Chosôn to include the web site.

<hr/> <i>Signature of person named above or Parent/Guardian if under age 18</i>	<hr/> <i>Date</i>
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