301 Pennsylvania Parkway, Suite 300
Indianapolis, IN 46280
Phone (888) 628-2818

2017 Volunteer Medical Form

Please print and complete this form; and return it to your site within two weeks.

All volunteers must sign the release below. Volunteers under the age of 18: In order to serve, all volunteers under the age of 18 must have a parent or legal guardian sign the release below.

In the event of my/my child's involvement in an emergency while at camp, I understand that every effort will be made to contact me. I hereby give permission for myself/my child to be treated by a physician selected by the camp and/or to receive general pain medication or over the counter allergy medication at the discretion of the first aid staff. I understand that failing to disclose some medical conditions may result in an inability of the camps to serve myself/my child. I understand that in order to best care for myself/my child, Impact 2818 reserves the right to decline attendance for myself/my child if the Camp Manager believes the camp is not able to provide quality care for myself/my camper regarding disclosed or undisclosed medical or behavioral needs. Also, I understand that pictures/video may be taken of myself/my child at camp and used for publicity purposes by Impact 2818.

Volunteer signature: _____ Printed name: _____

Parent/guardian signature: _____ Phone number: C H W (_____)_____-_____

Volunteer's name: _____ Event code: _____ *(ex. PC272)*

Address: _____

Medical Information:

Primary Care Physician: _____

PCP Phone #: (_____)_____-_____

Allergies: _____

History of: Asthma Seizures Severe allergy

Last Tetanus Shot? _____/_____/_____

Will you have any medications? Yes No

If yes, list all medications below (additional on back). All medication must be in its original container, labeled with your name, and given to the medic at check-in. **Please note herbal remedies, vitamins, and oils cannot be administered by the camp or counselors without a doctor's note.**

Insurance Information:

Are you covered by family medical/hospital insurance? Yes No

Policy holder's name: _____

Employer's name: _____

Relationship: _____

Insurance provider: _____

Group #: _____

Policy #: _____

Name of Medication	Dosage	Time to be Administered	Special Instructions
ex 1: Clarinex tablet *ex 2: Zyrtec syrup*	*5mg* *1 teaspoon*	*Breakfast* *As needed*	

Other medical information that will help us best serve you? _____

_____

Emergency Contacts:

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Number: C H W (_____)_____-_____ Number: C H W (_____)_____-_____

Number: C H W (_____)_____-_____ Number: C H W (_____)_____-_____

Questions? Go to BeACamper.com or call the registrar's office at (888) 628-2818.