



2010 Volunteer Medical History Form

Attention: This form is mandatory for your attendance at camp. The information collected is for the protection of the campers. Camp Quality Canada campers have a high risk of infection. As such, it is essential that volunteers are in good health and are clear of communicable disease. Please provide complete disclosure of any medical conditions. Failure to do so could impede the medical team's ability to best serve the campers or assist you throughout the week of camp.

Name: _____
(Last Name) (Given Name)

Address: _____
Street/P.O. Box/Apt

City Province Postal Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Emergency Contact Information

Physician's Name: _____ Phone Number: _____

Health Card Number: *Please have your card or card number available with you while at camp. In the case of an emergency, medical care will not be refused*

Contact #1: _____ Contact #2: _____
Relationship: _____ Relationship: _____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____
Address: _____ Address: _____

General Health and Medical History

Do you have or have you had any of the following? (*Please check any of the boxes that apply.*)

- | | |
|--|--|
| <input type="checkbox"/> Headaches (persistent) | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Skin Problems |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Stomach/ Bowel Problems |
| <input type="checkbox"/> Breathing Problems (eg. Asthma) | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Walking Problems |
| <input type="checkbox"/> Vision Problems (non-corrected) | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Emotional Problems |

If you answered YES to any of the above conditions, please complete the "Complete Medical Summary" section on page 2.

Specific Medical History

Please indicate if you have had the following illnesses:

Illness	Yes	No	Immunized	If yes, please indicate date
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rubella (German Measles)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Do you have a communicable blood spread disease? Yes No
 (Examples of communicable blood spread diseases are HIV and Hepatitis)

Are you pregnant? Yes No If yes, expected due date: _____

Have you had any major illnesses or operations: Yes No

If yes, please explain _____

Allergies

Allergy	Yes	No	If yes, please indicate reaction and usual treatment given.
Environmental	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication	<input type="checkbox"/>	<input type="checkbox"/>	_____
Food	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insects	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

Complete Medical Summary (Please complete this section if indicated on Page 1 in the **General Health and Medical History** section.)

Condition: _____

How long have you had this condition? _____

Are you seeing a specialist for this condition? _____

Do you take any medication for this condition? Yes No

Drug: _____ Dose: _____ Schedule: _____

Medications (other)

Will you require medications (including vitamins and supplements) while at camp?
Yes No Possibly If yes or possibly, please list
(disregard if medication is listed above):

Special Instructions:

Medication _____

Dosage _____

times per day _____

Note: All medication must be stored with the Medical Team for the duration of the camp week. It will be available for you to access at regularly scheduled times throughout the day or at another pre-arranged time.

Note: If you become sick or require medical attention prior to camp (within two weeks), please contact the Camp Director. We must be able to ensure that you are able to attend camp 2010. If you arrive at camp sick you will be sent home.

By signing below, I certify that all information included in this Volunteer Medical History Form is complete and correct. I also agree to immediately update this and all other forms in the volunteer application package, in writing, if and when any of the information provided therein becomes inaccurate or incomplete. I understand that this information is being collected to assist in protecting myself and the campers from all preventable health risks. I understand that the falsification, misrepresentation, or omission of information requested is grounds for refusal to accept my application or terminate my volunteer status with Camp Quality Canada now or in the future.

Signed: _____ Date: _____

The information provided by the applicant in this application will be retained and used by Camp Quality Canada, in providing services, to obtain medical and emergency care if required, to support promotional information (i.e. fundraising) and to facilitate ongoing communication. By providing this information, the applicant consents to the collection, use and disclosure of this information by Camp Quality Canada.