

Camp Kudzu

Staff/Volunteer Information and Health History Form



Directions: Sections A-H are to be completed by a staff/volunteer over the age of 18. This form is to be completed in its entirety and returned to the Camp Kudzu Office.

All Staff/Volunteers are required to complete, sign, and return this form prior to their camp experience.

Section A: Personal Information

Staff Name	Birth Date	Gender
Street Address		
City/State/Zip		
Home Phone	Cell Phone (or alternate phone)	
Email address		

Section B: Emergency Contact Information

In the event of an emergency, please contact (name)	Relationship
Address	
Home Phone	Cell Phone (or alternate phone)
Work Phone	Email address

Section C: Physician & Insurance Information

Endocrinologist Name (if applicable)	Phone
Physician Name	Phone
Insurance Carrier Name	Policy/Group Number
Name of Policy Holder	

Camp Kudzu Staff/Volunteer Information and Health History Form



Name	Birth Date	Gender
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Section D: Health History Information

Allergies – List All Known

Medication Allergies

Describe Reaction and Management of Reaction

Food Allergies

Describe Reaction and Management of Reaction

Other Allergies

Describe Reaction and Management of Reaction

Dietary Restrictions: _____

Medications

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Please note that this information will be kept CONFIDENTIAL by our healthcare staff. Thank you.

- I take no other medication (except for insulin) on a routine basis
- I take the following medication on a routine basis

1. Medication _____ Dosage _____
Specific times taken each day _____ Reason for Taking _____

2. Medication _____ Dosage _____
Specific times taken each day _____ Reason for Taking _____

3. Medication _____ Dosage _____
Specific times taken each day _____ Reason for Taking _____

4. Medication _____ Dosage _____
Specific times taken each day _____ Reason for Taking _____

Attach addition pages for more medications

Camp Kudzu

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General Health – Circle Yes or No

1. Had any recent injury or infectious disease?	YES NO	16. Ever had high blood pressure?	YES NO
2. Have a chronic illness other than diabetes?	YES NO	17. Ever been diagnosed with a heart murmur?	YES NO
3. Been hospitalized in the last 18 months?	YES NO	18. Ever had back problems?	YES NO
4. Had surgery in the last 18 months?	YES NO	19. Ever had problems with joints?	YES NO
5. Have frequent headaches?	YES NO	20. Have any skin problems (itching, rash, acne)?	YES NO
6. Ever had a head injury?	YES NO	21. Have asthma?	YES NO
7. Ever been knocked unconscious?	YES NO	22. Has mononucleosis in the past 12 months?	YES NO
8. Wear glasses, contacts, or protective eye wear?	YES NO	23. Had the chicken pox?	YES NO
9. Ever passed out during or after exercise?	YES NO	24. Traveled outside the country in the past 9 months?	YES NO
10. Ever been dizzy during or after exercise?	YES NO		
11. Ever had seizures?	YES NO		
12. Ever had chest pain during or after exercise?	YES NO		
13. Have a history of recurrent staph infections?	YES NO		
14. Ever had frequent ear infections?	YES NO		

If you marked “yes” on any of the above, please explain (use # to identify): _____

Dates and nature of serious injuries: _____

Please indicate any further information about your health needs that you feel we should know (restrictions, special needs, etc): _____

Please share any additional medical, physical, or emotional/psychological needs that you may have while at camp: _____

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Section E: Immunization History

Most adults will indicate "in childhood" or list dates if known

Immunization	Date
Year of Basic Immunization	_____
DPT (Diphtheria, Pertussis (DTaP) or (TdaP)	_____
Tetanus Booster (dt) or (TdaP)	_____
Mumps, measles, rubella (MMR)	_____
Polio (IPV)	_____
Varicella (chicken pox) or had chicken pox date	_____
Date of last tetanus	_____

If you have not been fully immunized or chosen not to be immunized, please sign the following statement:
I understand and accept the risks from not being fully immunized.

Signature: _____ Date: _____

Camp Kudzu Staff/Volunteer Information and Health History Form



Section F: Diabetes Information

If you are living with diabetes, please complete this portion of the form.

Name		Birth Date	Gender
Date diabetes diagnosed		Most recent HgbA1C Result	
History of ketoacidosis? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of episodes this year?	
Number of diabetes related hospitalizations this past year		Reasons	
History of hypoglycemia requiring medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No			
History of seizures with hypoglycemia? <input type="checkbox"/> Yes <input type="checkbox"/> No		Number of episodes in the past year?	

Injections

Insulin type (circle all that apply)					
NPH	Lantus (Glargine)	Levemir (Detemir)	70/30 mix	Regular	Humalog
Novolog	Apidra				
Insulin Brand (please circle)			Do you use an insulin pen? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Lilly	Novo	Aventis	Pen Type:		

Pump

Brand/Model Number	Serial Number	Insulin Type
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Pump & Lantus (both)

Brand/Model Number	Serial Number	Insulin Type
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Other Notes:

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Section G: Staff/Volunteer Member Authorizations

This health history is correct and complete to the best of my knowledge. The person herein described shall engage in both the physical and educational activities of camp except as noted in the restriction area. In case of medical and/or surgical emergency, you authorize Camp Kudzu's staff to render and arrange for medical care, including but not limited to any X-rays, anesthetic, medical, dental, surgical diagnosis, blood transfusions, treatment and hospital care which is deemed advisable by and is rendered under, the supervision of any physician, dentist, surgeon or other medical provider licensed to practice in the state of Georgia. Camp Kudzu will not be financially responsible for any costs or expenses associated with any medical treatments.

Signature: _____ Date: _____

Print name: _____

Return All Pages (1-6) and Forms to:

Camp Kudzu
577 Concord Road, Suite B
Smyrna, GA 30082
Fax 404.250.1812