



VOLUNTEER MEDICAL FORM

The information you provide on this form will be reviewed only by the Camp staff, doctors and nurses. Care will be taken to keep your information confidential from any other sources.

Name: _____ Age & DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
(H) Phone: _____ (W) Phone: _____
Cell Phone: _____ E-Mail: _____
Doctor's Name: _____ Phone: _____
Date of last visit: _____ Insurance Co.: _____
Policy Holder's Name: _____ Policy #: _____

Please provide a photocopy of your driver's license with this application.

IN CASE OF AN EMERGENCY, NOTIFY

1. NAME: _____ RELATIONSHIP: _____
(H) PHONE: _____ (W) PHONE: _____ CELL: _____

2. NAME: _____ RELATIONSHIP: _____
(H) PHONE: _____ (W) PHONE: _____ CELL: _____

What is your ability to perform physical activities that are essential to this volunteer job?

*Do you require any special accommodations to be made so that you may perform your duties? YES NO If Yes,

Explain _____

* The Camp SAM staff will do the best to make arrangements for special accommodations that you request; however, Camp SAM reserves the right to decide whether the request is reasonable and essential to the duties involved.

Do you have difficulty with the following: Ears Eyes Nose Throat Lungs Digestion Heart Diabetes Arms/Legs?

Please Explain: _____

List any other conditions we should be aware of Seizure Depression Eating Disorder Sleep Walking or Other, Please

Explain: _____

List any restrictions/limitations: _____

Describe any recent injuries, illness or surgery: _____

List medication(s) you take regularly & reason: _____

List any known allergies: _____

Are you allergic to Penicillin Other Medications? List _____

Foods? List _____ Bee Stings? Other? _____

Date of last tetanus shot: _____

Do you have any dietary restrictions or request? YES NO If Yes, Explain _____

If you have been exposed to any communicable disease(s), particularly chicken px (which is dangerous to children on chemo.), the month prior to a camp session/activity, please let us know as soon as possible.

RELEASE FORM:

This health history is correct as far as I know, and I hereby give my permission for the Camp Medical Staff, when necessary, to administer first aid treatment and to dispense medication to me. In the event that my next of kin cannot be reached in an emergency, I hereby give my permission to the physician selected by Camp Smile-A-Mile, to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for me as deemed necessary. Further, I hereby release and discharge, Camp Smile-A-Mile, and all other parties in interest, from all claims, demands, grievances and causes of action of every kind whatsoever, including, but not limited to, all liability from damages of every kind, nature and description, which may arise from, or out of injury occurred by myself while in attendance of this camp session, activity or trip.

Signature: _____ Date: _____

Please return completed from to: Jennifer Amundsen, Program Director, Camp Smile-A-Mile, P. O. Box 550155, Birmingham, AL 35255