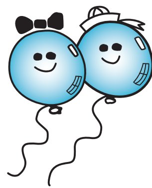


VACC CAMP

HEALTH FORM

Please fill out this form as completely as possible.

Name:		Date Of Birth:
Address:		
City:	State:	Zip Code:

Please get your vaccination records from your pediatrician and attach that to this health form.

HAVE YOU HAD ANY OF THE FOLLOWING?	YES	NO	UNKNOWN	IMMUNIZED FOR
CHICKEN POX				
RUBELLA (GERMAN MEASLES)				
MEASLES (SEVEN DAY)				

HAVE YOU EVER HAD A TUBERCULOSIS TEST? **YES** **NO** If not, you need to do a TB test.

WAS THE RESULT? **POSITIVE:** **NEGATIVE:** If you've had a TB test, you need to fill out the attestation included.

Do you have or are you being treated for?:

	Allergies		Hearing Problems
	Asthma		Immune Deficiency
	Chronic Cough		Skin Disorders/Rashes
	Diabetic on Insulin		Partial Blindness
	Epilepsy		Wrist, Back or Neck Injury

List all medications you are taking:

____

Describe any physical limitation (s) you have that staff should be aware of to help you participate fully as a camp volunteer:

____

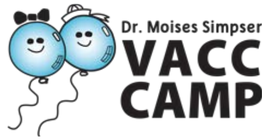
Physician: Name: _________________________ Phone: _________________

I authorize emergency treatment for myself if I am injured or taken ill during my service at camp if I am not able to give consent for my treatment and the staff is unable to reach my emergency contact .

SIGNATURE:____DATE: __________________

Parental Consent for Teen Volunteers (Under 18 years of age): I hereby consent to the participation of my daughter/son ___________________________as a camp volunteer. I authorize the emergency treatment of my daughter/son if s/he is injured or taken ill during volunteer service at camp if staff is not able to contact me for permission to treat.

SIGNATURE OF PARENT: ________________________ DATE: __________________



TB ATTESTATION

Name: ____________________________________ Phone No: __________________________________
Email: ____________________________________
Parent/Guardian Name: ____________________________

TB EDUCATION

Tuberculosis is a respiratory disease that can spread through the air from person to person. TB most often affects the lungs but can also affect the brain, kidneys, or spine. Symptoms of TB include weight loss, weakness, fever, night sweats, coughing up blood and chest pain. People with latent TB infection ("LTBI") have TB germs inside their bodies but the germs are inactive, and these individuals are asymptomatic. They cannot spread germs to others but are at risk of developing TB disease in the future.
Routine serial TB screening and testing for healthcare personnel without LTBI is not routinely recommended. TB screening may be indicated as a follow up of exposure during work activities, whenever the annual personal risk assessment indicates a potential for exposure or when the annual community and hospital tuberculosis risk assessment indicates a change from a low-risk facility for exposure to patients with active TB disease. All volunteers are required to have a risk review assessment for TB annually.

RISK ASSESSMENT

Check any that apply for the period of the last 12 months:

	Persistent cough for more than 3 weeks with sputum?
	Fevers in the afternoon or evening without other symptoms of infection?
	Coughing of blood?
	Loss of desire to eat or unexplained weight loss?
	Excessive fatigue?
	Frequent night sweats?
	Close contact with someone who has had infectious TB disease since the last TB test?
	Temporary or permanent residence of ≥ 1 month in a country with a high TB rate (*any country other than the United States, Canada, Australia, New Zealand, Northern or Western Europe)?*

VOLUNTEER ATTESTATION

I ATTEST THAT THE INFORMATION PROVIDED ABOVE IS ACCURATE. I ALSO UNDERSTAND SHOULD I DEVELOP SYMPTOMS AS OUTLINED ABOVE OR HAVE AN EXPOSURE TO A CLOSE CONTACT WITH TUBERCULOSIS AT ANY TIME DURING THE NEXT 12 MONTHS I WILL IMMEDIATELY CONTACT THE CAMP COORDINATOR.

Parent signature: ____________________________________ Date: __________________________

Bela Florentin, Camp Coordinator
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Email: bela.florentin@nicklaushealth.org