

Camp Mak-A-Dream Summer Staff & Volunteer General Medical Information - 2023

Please complete this form with as much information as possible, then **upload into your ACTIVE online profile** account.

'Camp Activities' typically include things such as walking, lifting, sports & rec activities, adventure course, swimming, etc.

Your First & Last Name: _____
Camp session(s) you are attending: _____ Dates: _____

This information and physical form must be complete & returned to Camp Mak-A-Dream prior to your arrival.

Have you ever had chicken pox? Yes No If yes, when? _____
If no, have you had a titer drawn? Yes No What were the results _____

Date of last tetanus booster: _____ Date of last chest X-ray: _____

Are your immunization up to date? Yes No (Up to date means: age-appropriate vaccinations including MMR, DTaP or Tdap, Varicella or titer test and TB, plus seasonal flu, COVID-19 vaccines)

Camp strongly supports vaccination for staff & volunteer for the safety of the camp community.

Current medical conditions/problems (headaches, asthma, seizures, etc.) or those that have required emergency medication(s) in the past that could preclude you from participating in or assisting with camp activities: _____

Significant medical history (surgery, injuries, serious illness, etc.) that could preclude you from participating in or assisting with camp activities: _____

Do you have any mental health issues that would prohibit you from fulfilling your duties at Camp? Yes No
If yes, please explain _____

Allergies (general/environmental, food, medications: prescription and over-the-counter): _____

Are you at risk of anaphylaxis due to the allergy? Yes No If anaphylaxis, are you bringing an epi-pen? Yes No

List any physical restrictions (chronic, acute and/or general) or limitations that would preclude you from participating in or assisting with camp activities: _____

Name and contact information for physician treating you for condition(s) listed above: _____

List any medications taken regularly (including over the counter): _____

Do you have medical insurance? Yes No If yes, insurance company's name: _____

Policy number: _____

Policy holder's name (if other than your own): _____

Group number (if applicable): _____

Prescription Drug Plan information: _____

Policy number: _____

Phone number: _____

X _____

Staff/Volunteer Typed Signature

Date

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