

Appendix "H"

CAMP HOBÉ PHYSICAL EXAMINATION FORM

Staff Member Name _____ Date of Exam _____

Diagnosis (if cancer pt) _____ Date of Diagnosis _____ Gender: M F

Code: Satisfactory (+) / Not Satisfactory (-) / Not Examined (O)

Height: _____ Weight: _____ Blood Pressure: _____

General Appearance: _____

Head: _____

Eyes: _____

Ears: _____

Nose: _____

Mouth/Throat: _____

Neck: _____

Chest/Lungs: _____

Cardiovascular: _____

Genitalia: _____

Musculoskeletal: _____

Nervous System: _____

Skin: _____

Central Line: _____

Laboratory: (if staff member is a cancer patient)

Date of CBC: _____

Results: WBC _____ ANC _____ HGB _____ HCT _____ Platelets _____

Date of Other Labs: _____

Chemistry (if indicated) Na _____ K _____ Cl _____ CO2 _____ BUN _____

Creatinine _____ Total Bilirubin _____ Other _____

In my opinion, this volunteer is medically appropriate to attend Camp Hobé: Yes No

Provider Name (print): _____ Signature: _____

Address _____

Phone Number _____

Appendix "T"

CAMP HOBE GENERAL HEALTH INFORMATION (Volunteer to Fill Out)

Volunteer Name: _____ Date Completed: _____

Height: _____ Weight: _____ Date of Birth: _____

Primary Diagnosis: _____

Physician's Name: _____ Phone: _____

EMERGENCY NUMBERS

NAME: _____ RELATIONSHIP: _____

PHONE: _____ home _____ cell _____ work _____

NAME: _____ RELATIONSHIP: _____

PHONE: _____ home _____ cell _____ work _____

PHYSICAL PROBLEMS OR LIMITATIONS: describe any activities in which you may not participate in for health reasons

EMOTIONAL / PSYCHOLOGICAL HEALTH: please indicate whether you have any of the following that may affect your ability to perform work/volunteer at camp

- Any emotional health concerns
- Any psychiatric diagnosis (such as depression, OCD, panic/anxiety disorder)
- An eating disorder
- A learning challenge

If you checked any boxes, please attach a statement that addresses the following with respect to camp:

- Describes the concern and your plan for managing it during camp, and
- Describes the support needed from your volunteer supervisor to complement your plan.

ALLERGIES

Medications: _____

Animals/Stings: _____

Foods: _____

Other (be specific) : _____

IMMUNIZATIONS (list date of last vaccination/booster, or mark as current)

_____ Measles	_____ Mumps	_____ Rubella	_____ Polio
_____ Diphtheria	_____ Pertussis	_____ Tetanus	_____ Varicella
_____ Pneumococcal	_____ Meningococcal	_____ Hepatitis A	_____ Hepatitis B
_____ Tb Test/ Result: _____		_____ Other _____	

