

Camp Hobé Physical Examination Form

Staff Member Name _____

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, or has a significant health problem)

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 and participate in Camp Hobé: Yes No

Signature: _____ Exam Date _____

Provider Name (print) _____

Office Address _____

Office Phone Number _____

Appendix F

Camp Hobé General Health Information (Volunteer to Fill Out)

Volunteer Name: _____ Date Completed: _____

Height: _____ Weight: _____ Date of Birth: _____ Gender: M F

Primary Diagnosis: _____

ALLERGIES None. Volunteer has no known allergies

Medications: _____

Animals/Stings: _____

Foods: _____

Other (be specific): _____

MEDICATIONS?

- Yes. Volunteer takes medication, vitamins, or supplements. See Medication Record
- None. Volunteer does not take medications, vitamins, or supplements

EMERGENCY NUMBERS

Physician's Name: _____ Phone: _____

Other Emergency Contacts:

NAME: _____ RELATIONSHIP: _____

PHONE: _____ home _____ cell _____ work _____

NAME: _____ RELATIONSHIP: _____

PHONE: _____ home _____ cell _____ work _____

LIMITATIONS: describe activities in which you may not participate 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.

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 _____		

