



## Camp Horizon Volunteer Health Form

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Emergency Contact Information:** Name: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Home (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

**General Health History:**

Last Ear Infection (date): \_\_\_\_\_

Circle: Heart Problems: Yes – No      Seizures: Yes – No      Diabetes: Yes – No  
Mumps: Yes – No      Measles: Yes – No      Asthma: Yes – No  
German Measles: Yes – No

**Immunization History:** (State requirement for licensed camp. All immunizations must be kept up to date.)

List dates: Last Tetanus Booster: \_\_\_\_\_ DPT Series: \_\_\_\_\_  
Last Tuberculin Test: \_\_\_\_\_ Polio Booster: \_\_\_\_\_  
MMR (Measles, Mumps, Rubella): \_\_\_\_\_ Other: \_\_\_\_\_

Recent/current infectious/communicable disease exposure? No – Yes, explain: \_\_\_\_\_  
\_\_\_\_\_

Allergies (circle): Yes – No: Hay Fever: Yes – No      Insect Stings: Yes – No  
Ivy Poisoning: Yes – No      Medications: Yes – No

List others: \_\_\_\_\_

Please list any dietary, activity, or other restrictions: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications:** All must be brought in original pharmacy containers. Be prepared to leave all medications with the camp medical staff. All medications will be kept in a secure location – away from campers – and will be available to you when needed. Please list your medications:

Drug	Dose	Time	Days of week

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please return to: [info@camphorizontn.org](mailto:info@camphorizontn.org), or  
Beyond the Horizon Corporation  
402 Dahlia Dr.  
Brentwood, TN 37027**