

The Vineyard

Vineyard International Counselor Program (V.I.C.P.) Health Form – Part A (Staff Form), 2010 Season

RETURN TO:
The Vineyard
1945 Vineyard Rd.
Westfield, NC 27053
USA
Tel: 1-336-351-2070
Fax: 1-336-351-2902
vicp@vineyardcamp.com
www.vineyardcamp.com



The parent or guardian must fill out this portion of the health form, if applicant is younger than 18 when applying.

Please check sessions(s) of attendance: A B C D E F G H I J K L M

Applicant's Full Name: _____ Birth Date: _____ (mm/dd/yyyy)

Social Security Number: _____ Age: _____ Gender: Male Female

1) Parent or Guardian (or Spouse): _____ Phone: _____

Home Address: _____

Street & Number, City, State, Zip Code, Country

Business Address: _____

Street & Number, City, State, Zip Code, Country, Phone

2) Second Parent or Guardian or Emergency Contact: _____ Phone: _____

Home Address: _____

Street & Number, City, State, Zip Code, Country

Business Address: _____

Street & Number, City, State, Zip Code, Country, Phone

3) If not available in an emergency, notify: _____ Phone: _____

Home Address: _____

Street & Number, City, State, Zip Code, Country

Business Address: _____

Street & Number, City, State, Zip Code, Country, Phone

Health History: (Check and give approximate dates)	Diseases	Allergies
Frequent Ear Infections <input type="checkbox"/>	Chicken Pox <input type="checkbox"/>	Hay Fever <input type="checkbox"/>
Heart Defect/Disease <input type="checkbox"/>	Measles <input type="checkbox"/>	Ivy Poisoning, etc <input type="checkbox"/>
Convulsions <input type="checkbox"/>	German Measles <input type="checkbox"/>	Insect Stings <input type="checkbox"/>
Diabetes <input type="checkbox"/>	Mumps <input type="checkbox"/>	Penicillin <input type="checkbox"/>
Bleeding/Clotting Disorders <input type="checkbox"/>		Other Drugs <input type="checkbox"/>
Hypertension <input type="checkbox"/>		Asthma <input type="checkbox"/>
Other <input type="checkbox"/>		
Mononucleosis <input type="checkbox"/>		

Operations or serious injuries (dates): _____

Dietary modifications: _____

Current medication (send with instructions): _____

Other diseases or details of above: _____

Name of dentist/orthodontist: _____ Phone: _____

Name of family physician: _____ Phone: _____

Date of last physical examination: _____ Do you carry family medical/hospital insurance?

If so, indicate: Carrier, policy or group #, address, telephone # and copy of medical insurance card

Suggestions or health related information for camp personnel: _____

(For Female): Has this person menstruated? If not, has she been told about it?

If so, is her menstrual history normal? Special consideration: _____

EMERGENCY AUTHORIZATION: I hereby give permission to the medical personnel selected by the camp director to order Xrays, routine tests and treatment for me/or my child and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me/or my child as named above. The infirmary staff will administer all medications including prescribed and non-prescribed medications. This form may be photocopied for use out of camp.

SIGNATURE OF PARENT/GUARDIAN OR ADULT CAMPER/STAFFER: _____

SIGNATURE OF WITNESS OR SPOUSE: _____

DATE: _____

The Vineyard

Vineyard International Counselor Program (V.I.C.P.) Health Form – Part B (Doctor’s Form), 2010 Season

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Please have your family physician fill out this form.
An examination is required annually for camp registration.
Immunizations **MUST** be current.

Please check session(s) of attendance: A B C D E F G H I J K L M

Applicant’s Full Name: _____ Birth Date: _____ (mm/dd/yyyy)

IMMUNIZATION HISTORY

Please record the date (MONTH and YEAR) of basic immunizations and most recent booster doses:

Vaccines	Month / Year of Basic Immunization	Month / Year of Last Booster
Diphtheria) Pertussis (Whooping)) DPT* Tetanus)	1) 2) 3)	1) 2)
or		
Tetamis) Diphtheria) TD* or		
Tetanus		
Oral Polio (Sabin) * TOPV		
Injectable Polio (Salk)		
Measles (hard measles, red measles, Rubeola)		
Mumps		
Rubella (German measles, 3-day measles)		
Other		
Tuberculin test given	(most recent)	

Health Examination by Licensed Physician:

I have examined the above camp applicant. _____ (Signature) | Date Examined: _____

In my opinion, the above’s condition does /does not preclude his/her participation in an active camp program.

The applicant is under the care of a physician for the following condition(s):

Current treatment (include current medications):

Explanation of any reported loss of consciousness, convulsion, or concussion:

Does applicant have epilepsy? Yes / No | Does applicant have diabetes? Yes / No

Recommendations and restrictions while at camp:

Any treatment to be continued at camp:

1. Any medication to be administered at camp (specific dosages):
Medication must be brought in original containers

2. Any medically prescribed meal plan or dietary restrictions:

Any allergies (food, drugs, plants & insects, etc.):

LICENSED PHYSICIAN SIGNATURE: _____

DATE: _____ (mm/dd/yyyy)

ADDRESS: _____

Street & Number, City, State, Zip Code, Country, Phone