



# CAMP BOB AT KANUGA

## VOLUNTEER Registration/ Health Form

### Participant and Parent/Guardian Information

Dates of Attendance: \_\_\_\_\_

Participant Name: \_\_\_\_\_  
Last First Middle

Gender:  Male  Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_

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

E-mail: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone Numbers:(\_\_\_\_)\_\_\_\_-\_\_\_\_  
(\_\_\_\_)\_\_\_\_-\_\_\_\_

### Medical Information\*

Does the participant take any medication?  Yes (if "yes" please describe below)  No

Please list any medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep medications in their original packaging/ bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Does the participant have any allergies?  Yes (if "yes," please describe below)  No

Does the participant have any medical history or restrictions that may limit participation or affect them while at camp?

Yes (if "yes," please describe below)  No

### Participant or Parent/ Guardian Authorization & Acknowledgement of Risk

I give permission to the medical personnel selected by the president of Kanuga Conferences, Inc. or his designee to provide routine health care; to administer medications; order X-rays, routine tests, treatment; to release any records necessary for insurance purposes, and to provide or to arrange necessary related transportation for me/my child. In an emergency, I give permission to the medical personnel so selected to secure and administer treatment including hospitalization for me/my child. I give permission for photographs, audio/ video recording of my child to be used by the camp for its promotion, web site, and/ or news media coverage.

I acknowledge that there are inherent risks to participation in recreational and adventure activities and programs sponsored by Kanuga Conferences, Inc, including, but not limited to swimming, canoeing, climbing, and ropes courses that could result in accidental injury, possibly serious. Parents will be notified immediately if a problem is serious. Furthermore, engagement in these activities requires good physical condition on behalf of the participant. Being aware of the inherent risks and potential injury to myself/my child, I hereby consent to my/my child's attendance and participation in the activities sponsored by Kanuga Conferences, Inc.

Signature of participant or parent / guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**General Health Questions (Explain “yes” answers below)**

Has/ does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness, or infectious disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/ condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had problems with joints? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized? .....	<input type="checkbox"/>	<input type="checkbox"/>	18. Have an orthodontic appliance being brought to camp? .....	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery? .....	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems? .....	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury? .....	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious? .....	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the last 12 months? ..	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts, or eyewear? .....	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea/ constipation? ..	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections? .....	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking? .....	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise? ...	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise? ...	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting? .....	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures? .....	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever had emotional difficulties for which professional help was sought? .....	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur? ..	<input type="checkbox"/>	<input type="checkbox"/>			

Explain any yes here:

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- Which of the following has the participant had?
- Measles
  - Chicken Pox
  - German Measles
  - Mumps
  - Hepatitis A
  - Hepatitis B
  - Hepatitis C

- Which of the following immunizations has the participant had?
- DTP
  - MMR
  - Rubella
  - Haemophilus influenza B
  - Polio
  - Measles
  - Hepatitis B
  - TD (tetanus/ diptheria)
  - Mumps
  - Varicella (chicken pox)

Date of last Tetanus shot (Month/Date) \_\_\_\_\_

Name of regular physician or health care facility \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Is the participant covered by an insurance plan?  Yes (if “yes,” please describe below)  No

Plan Name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company address: \_\_\_\_\_

Name of insured/policy holder: \_\_\_\_\_ Relation to participant: \_\_\_\_\_

Policy ID number or Social Security number of policy holder: \_\_\_\_\_

Use this space to provide any additional information about the participant about which the camp should be aware: \_\_\_\_\_

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**Racial/ Ethnic Identity**

You are not required to answer these questions. If you choose to do so, mark one of the following racial or ethnic identities:

- American Indian or Alaska Native
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- Asian
- White

# CAMP BOB VOLUNTEER GUIDELINES

## SEXUAL HARASSMENT AND CHILD ABUSE

**Harassment:** Camp Bob Summer and Kanuga Conferences is committed to providing an environment that is free of harassment. In keeping with this commitment, Camp Bob Summer maintains a strict policy prohibiting unlawful harassment. The term “harassment” includes, but is not limited to verbal, graphic, or physical conduct which relates to an individual’s race, color, religion, sex, national origin, age, or disability. Sexual harassment consists of unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature. All forms of harassment will not be tolerated. This policy prohibits harassment in any form, including verbal, physical, psychological, and visual.

**Child Abuse:** Camp Bob Summer and Kanuga Conferences is committed to providing an environment that is free of child abuse, and maintains a strict policy prohibiting any kind of child abuse. Child abuse is the mistreatment or neglect of a child resulting in injury or harm. If a volunteer suspects child abuse, please contact the Camp Director immediately. It is North Carolina law to report suspicion of child abuse. Do not engage in an activity exclusively with one child. Find another adult to be present with you and the child.

**Procedures:** As a volunteer, you are responsible for documenting and reporting any harassment or abuse to the Camp Bob Summer administrative staff. The person to whom the report is made will ensure that the report is passed expediently to an appropriate supervisor. Any supervisor to whom an allegation is made will investigate the allegation and in turn promptly report the allegation and any associated developments to the President of Kanuga Conferences.

## ALCOHOL POLICY

Illegal or improper use of alcohol will not be tolerated. No alcoholic beverages are permitted at the Bob Campbell Youth Campus. Volunteers should NOT consume alcoholic beverages at any time prior to work responsibilities, or discuss personal use of alcoholic beverages in the vicinity of campers.

## ILLEGAL/PRESCRIPTION DRUGS

The use of illegal drugs and the misuse of prescription drugs will not be tolerated.

## SMOKING

No smoking is allowed. Volunteers are expected to set an example for the campers.

I have read and understand the above guidelines as they pertain to Camp Bob Summer Volunteers. (Kanuga Staff are also bound by similar guidelines.) I will comply to the above guidelines and any other policies set forth in the Volunteer Manual. I understand that Camp Bob Summer will take seriously any allegations or suspicions of child abuse and will report such allegations or suspicions to the police and state agencies for investigation. I understand that Camp Bob Summer may take disciplinary action or terminate volunteer service of any person who does not adhere to these guidelines.

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