



VOLUNTEER

Health History and Release Form

2018 WV Envirothon

Please make 1 copy which will be kept on file with the nurse. Please complete to the best ability possible. All forms will be shredded after the event. The forms may be placed inside an envelope to turn in. **Please indicate on the outside of the envelope if you agree to the publicity release.**

Name _____
Last First Middle Suffix

Home Address _____

Gender: Male Female Birth Date ____/____/____ Age at Event _____

Second Emergency Contact _____

Relationship _____

Home Address (if different from above) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Third Emergency Contact _____

Relationship _____

Home Address (if different from above) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Insurance Information

Company _____ Policy Number _____ Group Number _____

Insurance Address _____

Insurance Phone Number _____

I understand that while all reasonable efforts will be made to provide a safe environment, certain risks are involved. I understand that any person or entity associated with the WV Envirothon is not liable in the case of accidental injury or illness. I hereby further understand that in case of serious injury or illness, I will be notified. If it is impossible to contact my emergency contacts, I hereby give permission for emergency treatment or surgery as the attending physician recommends. This health history is correct and complete as far as I know, and the person herein described has permission to engage in all WV Envirothon activities. I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to the camp to arrange necessary related transportation for me. In the event my emergency contacts cannot be reached in an emergency, I hereby give permission to the physician selected by the camp to secure and administer treatment, including hospitalization.

Signature _____ Date _____

Physician Name: _____

Physician Phone Number: _____

Dentist Name: _____

Dentist Phone Number: _____

Medications Taken: Please list all medications taken routinely, dosage, and frequency.

General Questions: (Explain any "yes" responses below)

	Yes	No
1. Had recent injury, illness or disease	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic illness/condition	<input type="checkbox"/>	<input type="checkbox"/>
3. Have frequent headache	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had seizures	<input type="checkbox"/>	<input type="checkbox"/>
5. Ever had a head injury	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had chest pain	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever had high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
8. Ever been diagnosed with a heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
9. Have joint or back problems	<input type="checkbox"/>	<input type="checkbox"/>
10. Have diabetes	<input type="checkbox"/>	<input type="checkbox"/>
11. Have asthma	<input type="checkbox"/>	<input type="checkbox"/>
12. Allergic to anything (including bee stings, poison, etc)	<input type="checkbox"/>	<input type="checkbox"/>

Please explain any "yes" answers, noting the number of the question(s) below.

Publicity Release: I authorize the WV Envirothon Committee to use my name, photo, and/or materials produced for future use including, but no limited to, educational resources, press releases, web based publicity and other publicity materials. _____ Yes _____ No

Signature _____ Date _____