

COLLEGE OF YOGA SCIENCES

DAY CAMP

Volunteer Application Form

Age 18 and above

Mail to: Mr. Om Baweja, 113 Econlockhatchee Trail, Orlando FL 32825, TEL 407-275-0013

Pease fill out separate form for each volunteer.

Volunteer First Name: _____ Last Name _____

Date of Birth (mm/dd/yyyy) : _____

Phone (Home): _____ Phone (Office): _____

Phone (Emergency): _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

I am experienced in the following:

Please put a X, if experienced in the following

Kabadi Arts & Crafts Yoga Environmental awareness Skits and dramas
 Kho kho Stories Origami Trataka Meditation Sports & games

Medical Insurance: Medical Insurance Company Name:

Group #: _____ Subscriber #: _____

Personal Physician's name: _____ Physician's phone: _____

Consent

- I hereby release College of Yoga Sciences, HUA and its officers of any liability for any accidents or injuries may incur wh am attending the Camp.
- I and my health insurance company are completely responsible for the payment of all expenses incurred for any kind medical and/or surgical treatment as a result of my participation in the camp.
- In the event of an emergency where treatment by a doctor is deemed necessary, I hereby give permission fo representative of the College of Yoga Sciences, HUA to authorize physician(s) and hospital personnel to give my child anesthesia and/or perform whatever medical and/or surgical treatment deemed necessary at such time in my child's t interest.

Signature of the Volunteer _____ Date: _____

COLLEGE OF YOGA SCIENCES

MEDICAL :

DAY CAMP

Medical Form

Name of Participant: _____

Date of Birth (mo/day/yr): _____ Height: _____ Weight: _____

Male: _____ Female: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact's Phone(s): _____

Family Physician: _____ Phone: _____

Family Medical Insurance co.: _____ Policy #: _____

Health History: Check those that apply and explain any illness checked below o attach a sheet:

Chicken Pox	___ Yes ___ No	Learning Difficulties	___ Yes ___ No
Measles	___ Yes ___ No	Physical/Social/Emotional Needs	___ Yes ___ No
German measles	___ Yes ___ No	Hypertension	___ Yes ___ No
Mumps	___ Yes ___ No	Asthma	___ Yes ___ No
Mononucleosis	___ Yes ___ No	Bleeding Disorders	___ Yes ___ No
Seizure	___ Yes ___ No	Diabetes	___ Yes ___ No
Epilepsy	___ Yes ___ No	Operations/Serious Injuries.	___ Yes ___ No
Ear Infection	___ Yes ___ No	Chronic/Recurring Illness	___ Yes ___ No
Heart Disease/Defect	___ Yes ___ No	Dietary Restrictions	___ Yes ___ No
Musculoskeletal Disorder	___ Yes ___ No		

Allergies (list)

Food	___ Yes ___ No	Animal	___ Yes ___ No
Drug	___ Yes ___ No	Hay Fever	___ Yes ___ No
Insect Sting	___ Yes ___ No	Plant/Pollen	___ Yes ___ No

Other: * _____

COLLEGE OF YOGA SCIENCES

MEDICAL 2

DAY CAMP

Camper's Application Form

Name of Participant: _____

Special Conditions to be watched for (i.e. wetting, fainting, menstrual cramps, etc.) *: _____

Hospital / Emergency visit during the last 6 months? : ____ Yes: ____ No: If yes then for what reason? * _____

This health history is correct as far as I know and the person described has permission to engage in all camp activities except as noted above. I will notify Camp authority if there is any change in health conditions of the participant.

I give permission:

- 1) To the medical personnel selected by the Camp authority to hospitalize, secure proper treatment such as anesthesia or surgery, and to provide or arrange necessary transportation for the participant.
- 2) For Camp Health Supervisor to treat minor injuries or illness as directed by orders of a licensed physician; administer Prescription medication brought to camp in it's original container, labeled with the participant's name, physician' name and dosage; and/or administer over- the- counter medication unless otherwise specified below.

Medications: List of over-the-counter medication that **may not** be administered to the participant: *

The participant does **NOT** take any medication on a routine basis: _____

The participant takes the following medicines (Please include ALL medications and attach sheet for more): *

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 _____

Signature (Parent or Guardian for participant under 18) _____ Date _____

To be completed by Licensed Physician or State Approved Nurse Practitioner

Name of Participant: _____

Date of Examination (must be within last two years): _____.

In my opinion, this person's condition allows participation in active camp program subject to the following limitations, restrictions, and treatment to be continued at the camp.