CAMP FIRE MEDICAL INFORMATION FORM

Camp Fire
Light the fire within

Program Name_____ Youth ☐ Adult ☐

Name _____
Last First Middle

Address _____
Number and Street City, State and Zip

Date of Birth_____ Sex_____ Age_____ Phone (_____) _____

Parent/guardian/emergency contact _____

Cell (_____)_____ Work (_____) _____

Names of two alternates who may be contacted in case of emergency:_____

1. Name_____ Relationship_____ Phone (_____) _____
2. Name_____ Relationship_____ Phone (_____) _____

Council Name_____ Phone (_____) _____

Name of family physician_____ Phone (_____) _____

Name of family dentist _____ Phone (_____)_____

Date last seen by family physician_____ Name and identification

Number of family hospital/medical insurance _____

Employer through which insurance is received _____

If participant has been under the care of a physician within the past 12 months or if there is any question about activity restriction, attach a statement from a physician indicating restrictions and noting any pertinent recommendations.

1. Any operations, serious injuries or chronic illnesses_____If yes, specify:
   _____
2. Check communicable diseases to date: ☐ Chicken Pox
   ☐ Other_____
3. Has child been immunized to attend school? _____
4. Give date of last Tetanus shot _____
5. Name any known allergies: Food_____Drugs_____
   Plants_____Animals_____Insects_____Other _____
   Explain reaction and indicate medication used _____
   _____

(Medication for above should be brought with you.)

Note: The information requested is only to protect the safety of the participant and others. Camp Fire is committed to and does comply with the Americans with Disabilities Act in all respects and will utilize the information provided on this form only for the protection of the participant and other participants and/or to assist in making the accommodations required to permit the participant to fully take part in this Camp Fire activity.

6. Check if prone to any of the following conditions:
   ☐ Fainting ☐ Convulsions ☐ Stomach Upsets ☐ Frequent Headaches
   ☐ Asthma or Respiratory Problems ☐ High Blood Pressure ☐ Heart Problems
   ☐ Restlessness or Sleepwalking ☐ ADD/ADHD ☐ Other _____
   Any disability requiring accommodations in the form of special attention, auxiliary aids or services, removal of physical or communications barriers, etc. (please specify)
   _____

7. The following are the auxiliary aids, services and/or special attention that I/my child require(s) to engage in the Camp Fire activity or event, as well as the physical and/or communications barriers that may need to be removed for me/my child to participate in the event: _____
   _____

8. List medication(s) and use, including insulin. (Should be in original container with prescription and/or store label.)
   Medication_____used for_____when taken_____
   Medication_____used for_____when taken _____
   Do you need any assistance administering medication? _____ Is refrigeration needed?_____ Please explain _____

8. Any prior activity restriction?_____ If yes, specify_____
   _____
   Any present activity restriction desired by participant, his or her parent, guardian or physician?_____ If yes, specify _____

I have completed the above information (with my parents, if a minor) and will assume the responsibility for restricting any activities agreed upon and listed above. I will exercise good judgement in regard to my own health, safety and well being at the Camp Fire event described above.

Signed_____ Date_____

I verify that the above medical information on my child, _____, is complete and accurate. I also understand that reasonable measures will be taken to safeguard the health and safety of all participants and that I will be notified as soon as possible in case of any emergency affecting such participant. In the event I cannot be reached in an emergency, I hereby authorize the calling of a physician at my expense to provide whatever emergency medical, dental or surgical treatment is necessary.

Signed _____Date_____

(Parent or Legal Guardian)