

Medical Information Form

To be Completed by a Parent or Guardian of the Camp Participant

Please return this form by June 2nd to: Camp Fire USA, 2700 Clark St., Missoula, MT 59801

(Please print neatly)

Name _____ Date of Birth _____ Sex: _____

Address _____

City _____ State _____ Zip _____

Parent/Guardian's Name: _____

Address _____ City _____ State _____ Zip _____

Home # () _____ Work Phone# () _____ Cell # () _____

Parent/Guardian's Name: _____

Address _____ City _____ State _____ Zip _____

Home # () _____ Work Phone# () _____ Cell # () _____

****Alternate Emergency Contact Person _____ Relationship _____**

Address _____

Phone # () _____ or Phone # () _____

1. Please indicate your hospitalization information for emergency use.

Carrier _____ Policy # _____

Group Policy # _____

Address of Carrier _____

Parent SS# _____

2. Name of family physician _____ Phone # () _____

3. Has there been any history of the following? Please explain any checked item on a separate piece of paper.

Allergies

Asthma

Headaches

Cramps

Eating Disorders

Foot Problems

Epilepsy

Injuries of any kind

Heart Problems

Hepatitis

Mononucleosis

High Blood Pressure

Phobias

(claustrophobia, etc.)

Pneumonia

Back Problems

Chronic Pain

Diabetes

Dizziness

Infectious Disease

Fainting

Recurrent Dental

Problems

Lyme Disease

Mental Illness

Gastrointestinal

Problems

4. List medications, what it is used for, dosage, and when it should be taken (should be original container with prescription and/or store label). Use separate sheet if needed.

5. Do you give permission for the Camp Nurse to administer (check all that apply):

Benadryl _____ Hydrocortisone Cream _____ Motrin _____ Tylenol _____

6. Are there any dietary considerations we should know about? Explain on a separate sheet if needed.

7. Any prior activity restriction? _____ If yes, please explain.

Any present activity restriction? _____ If yes, please explain.

8. Please provide any additional information (below or on a separate attached sheet) about the participant's physical, emotional or mental health about which the program staff should be aware.

I 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 emergency, I hereby authorize the calling of an ambulance and/or physician at my expense to provide whatever emergency medical or surgical treatment is necessary.

Parent/Guardian Signature _____ Date _____

