CAMP FIREWALKER
HEALTH AND MEDICAL RECORD

Name _____ Phone _____ Date of Birth _____
Address _____ City, State, Zip _____

Family Medical Insurance Company _____ Policy # _____
Insurance Company Address _____ Phone # _____
City, State, Zip _____
Please attach a copy of your Insurance Card. If you have none, so state.

EMERGENCY POINT OF CONTACT:
Name _____ Relationship _____
Address _____ Phone # _____
City, State, Zip _____ Bus Phone # _____
Alternate Contact _____ Phone # _____

PARTICIPANT HEALTH RECORD

Are you now, or have you ever been treated for any of the following: (Answer yes or no)

	Y	N		Y	N		Y	N		Y	N		Y	N
Sinus Trouble			Kidney disease			Earaches/infections			Abdominal problems			Rheumatic fever		
Hay fever			Tuberculosis			Fainting spells			Epilepsy			Asthma		
Heart trouble			Diabetes			Frequent Diarrhea			Any mental illness					
Allergy to bee, wasp or hornet stings			Allergies or reactions to any medication			Explain:								

For women: menstrual problems YES/NO

Have you had more than a brief minor illness (24 hrs or more), injury or emotional difficulty during the past year? Yes/No
If so, what? _____
Operations or serious injuries or hospitalization (for any reason) within the past 36 months (dates) _____
Any restriction of activity for medical reasons? Yes/No Explain _____
Have you taken any medication for more than two weeks in the past year? (What & Why) _____
Are you now taking medication or treatment? (Why?) _____

List current medications and dosages:

Medications	Dosage
NOTE: BE SURE TO BRING MEDICATION THAT MAY BE NEEDED AT CAMP	

PARENT'S/GUARDIAN'S AUTHORIZATION - REQUIRED FOR THOSE UNDER 18 YEARS OF AGE.
I, the undersigned, have read and understand this entire form, including the sections entitled "Physician Please Note." This health history of the applicant is accurate and complete and the person herein described has permission to engage in all Camp Firewalker activities described, except as specifically noted by me or the physician on this form. If I cannot be reached in an emergency, I hereby give permission to the physician selected by Firewalker, or the adult advisor in charge, to treat, hospitalize, secure anesthesia or to order injection, surgery or other treatment for the person described herein and Camp Firewalker has permission to obtain all information connected with treatment by a physician, hospital or other treatment facility.

INFORMATION ABOVE IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND I GIVE MY CHILD PERMISSION TO ATTEND CAMP FIREWALKER AND PARTICIPATE IN HIGH ADVENTURE ACTIVITIES.

Applicants signature _____ Parent/Guardian signature _____
Date _____ Date _____