



# Camp Fire USA Heartland Program and Innovation Center Medical Information Form

HEARTLAND PROGRAM AND INNOVATION CENTER  
1100 WALNUT STREET, SUITE 1900, KANSAS CITY, MO 64106  
816-285-2010 phone  
816-285-9444 fax  
www.campfireusa.org

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Number and Street City State Zip Code

Age: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Preferred parent to call first: \_\_\_\_\_

First Parent Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Second parent Work Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

Name of two alternates who may be contacted in case of emergency:

1. Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone: \_\_\_\_\_

Give 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.**

Any operations, serious injuries or chronic illness: \_\_\_\_\_ If yes, specify: \_\_\_\_\_

List communicable diseases to date: Chickenpox \_\_\_\_\_ Other \_\_\_\_\_

Has child been immunized to attend school: \_\_\_\_\_ Yes \_\_\_\_\_ No

Has child received chickenpox vaccine: \_\_\_\_\_ Yes \_\_\_\_\_ No

Date of last tetanus shot: \_\_\_\_\_

Name any known allergies: Food \_\_\_\_\_ Drugs \_\_\_\_\_ Plants \_\_\_\_\_

Animals \_\_\_\_\_ Insects \_\_\_\_\_ Others \_\_\_\_\_

Explain reaction and indicate medication used \_\_\_\_\_

(Medication for above should be brought with you)

Check if prone to any of the following: Fainting \_\_\_\_\_ Stomach upsets \_\_\_\_\_ Convulsions \_\_\_\_\_

Asthma or respiratory problems \_\_\_\_\_ Bedwetting \_\_\_\_\_ Sleepwalking \_\_\_\_\_ Heart Problems \_\_\_\_\_

ADD/ADHD \_\_\_\_\_ High blood pressure \_\_\_\_\_ Frequent Headaches \_\_\_\_\_

Any known physical, mental or social difficulties which may affect participation and/or which special consideration should be given? \_\_\_\_\_ Explain: \_\_\_\_\_

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 \_\_\_\_\_

Medication \_\_\_\_\_ used for \_\_\_\_\_ when taken \_\_\_\_\_

Special diet needs or requests \_\_\_\_\_

Any activity restriction desired by participant, his or her parent, guardian or physician? \_\_\_\_\_

If yes, describe \_\_\_\_\_

\*Please Note: Camp Fire USA has a limited insurance policy. The family will be responsible for the amount in excess of the insurance coverage.

With my parent, (if a minor) I have completed the above information and will assume the responsibility for my medications and for restricting any activities agreed upon and listed above. I will exercise good judgment in regard to my own health, safety and well-being while participating at camp.

Participant Signature \_\_\_\_\_ 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 my child. In the event, I cannot be reached in an emergency, I hereby authorize Camp Fire USA to obtain medical attention for my child at my expense to provide whatever emergency medical, dental or surgical treatment is necessary.

Parent/legal guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_