

PERSONAL HEALTH AND MEDICAL RECORD: CLASS 1

Class 1 (update annually for all participants). Activity: Day camp, overnight hike or other programs not exceeding 24 hours, with level of activity similar to that of home or school. Medical care is readily available. Current personal health and medical summary (history) is attested by parents to be accurate. This form is filled out by all participants and is on file for easy reference.

ADULT PARTICIPANT

To be filled out by adult participant, use one form per adult. Please print in ink.

IDENTIFICATION:

Adult's Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Name of Next of Kin: _____ Telephone H): _____ B): _____

Home Address: _____ City: _____ State: _____ Zip: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Name of Personal Physician: _____ Telephone: _____

Personal health/accident insurance carrier: _____ Policy No.: _____

If person named above is not available in the event of an emergency, notify:

Name: _____ Relationship: _____ Telephone: _____

Name: _____ Relationship: _____ Telephone: _____

Complete the following section relating to your health history, past and present. Explain any "YES" answers.

ALLERGIES: Food, medicines, insects, plants YES (___), NO (___) Explain: _____

GENERAL INFORMATION:	YES	NO		YES	NO
Asthma	()	()	Diabetes	()	()
Cancer/Leukemia	()	()	Heart Problems	()	()
High Blood Pressure	()	()	Convulsions/Seizures	()	()
Kidney Problems	()	()	Hemophilia	()	()

Explain: _____

List any medication to be brought and taken at camp (ALL MEDICATION MUST BE IN ORIGINAL CONTAINER AND LABELED WITH INSTRUCTIONS ON HOW TO GIVE): _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances or playing strenuous physical games: _____

List equipment needed such as wheelchairs, braces, glasses, contact lenses, etc.: _____

IMMUNIZATIONS: (You **must** complete this section with the date, this shot is good for 10 years. If you haven't had it write "Not within 10 years" or better yet – Get the shot!))

Tetanus Toxoid: _____

In case of emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or prescription of medications for my child. The signature of the parent/guardian is required and indicates that all information is correct, up-to-date and that a physical by a licensed physician occurred within the last 36 months.

Signature Parent/Guardian: _____ Date: _____