

CAMPFIRE MINISTRIES

PARTICIPANT MEDICAL INFORMATION FORM 2011

Medical form must be completed before you may attend camp

The purpose of this form is to help our instructors provide the best care for you or your child. Information on this form is considered confidential and will only be shared with medical personnel in the event of an emergency. **This information will not be used to deny you or your child access to the program.**

PARTICIPANT INFORMATION

Participant's Name: _____

Address: _____

Street

City/Town

Province/State

Program Date: _____

Phone: _____ Date of Birth (d/m/y): ____ / ____ / ____

Age: _____ Gender: M F

Doctor's Name: _____ Doctor's Phone Number (____) _____

BC Care Card Number (for BC residents only): _____

Other Health / Medical Insurance Provider: (for non-BC residents) _____

Number: _____

MEDICAL HISTORY

1. Please list any DIETARY RESTRICTIONS:

2. Please indicate known ALLERGIES to foods, medications, insect bites and others:

Allergen/Trigger

Reaction (If anaphylactic, participant **must** bring 2 Epi-Pens) Treatment:

3. Date of last TETANUS IMMUNIZATION OR BOOSTER (Year) _____ (Children in BC receive tetanus boosters in Kindergarten and grade 9. Adults are recommended to have a booster every ten years.)

4. Are you or will you be taking any PRESCRIPTION OR NON-PRESCRIPTION DRUGS currently or while at Campfire Ministries? YES NO

5. Please circle below if you experience any of the following CHRONIC CONDITIONS:

ADHD	Motion Sickness	Frequent Colds	Epilepsy	Night terrors
Asthma	Balance/Vertigo	Nosebleeds	Kidney Trouble	Sleep Walking
FAS	High Blood Pressure	Headaches	Heart Condition	Anxiety
Fainting	Diabetes	Other (specify) _____		

If YES to any of the above, please explain:

PLEASE DESCRIBE YOUR:

EYESIGHT: Excellent Good Fair Poor Glasses Contacts

HEARING: Excellent Good Fair Poor Require Electronic Hearing Aid

PHYSICAL CONDITION: Excellent Good Fair Poor

SWIMMING ABILITY: Able to swim 100m Able to swim 25m Non-swimmer

Non-swimmers: are you comfortable in deep or moving water while wearing a lifejacket or PFD? **YES NO**

7. Have you been under a DOCTOR’S CARE in the last 12 month? **YES NO**
If YES, for what reason? _____

8. Do you have a history of JOINT PROBLEMS (arthritis, tendonitis, bursitis, sprains, dislocation, etc.)?
YES NO
If YES, please describe: _____

9. Do you feel you have any PHYSICAL CONSIDERATIONS that could limit your participation? **YES NO**
If YES, please explain: _____

10. Do you feel you have any PSYCHOLOGICAL CONSIDERATIONS (fear of heights, etc.) that could limit your participation? **YES NO**
If YES, please explain: _____

11. List any other factors that may affect your participation in Campfire Ministries Adventure Challenge programs:

IN CASE OF EMERGENCY CONTACT: *(please provide two)*

Name: _____ Relationship: _____

Home Phone:(_____) _____ Alternate Phone:(_____) _____

Name: _____ Relationship: _____

Home Phone: (_____) _____ Alternate Phone: (_____) _____

I hereby give my consent and full authority to the staff of Campfire Ministries to arrange for, and consent to, any emergency medical treatment or hospitalization for the Participant, and to enter into and execute, on my behalf, such documents or consents as may be required by Physicians, Health Care Professionals, Dentists or Hospitals for such purposes.

I have completed this medical form accurately, truthfully, and to the best of my knowledge as of today’s date. I understand that it is my responsibility to inform Campfire Ministries of any new medical condition or change to this information before the program begins. I recognize that falsification or omission of information is grounds for removal from the program.

Signature of Adult Participant or Custodial Parent/Guardian (for minors):

Signature

Please print name

Date