

**CAMPFIRE MINISTRIES**  
**STAFF & CLT MEDICAL INFORMATION FORM 2012**

All information given on this form is confidential.

**Medical form must be completed before you may attend camp.**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Male  Female  Age: \_\_\_\_ Date of Birth: d \_\_\_\_\_ m \_\_\_\_\_ y \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Parent(s)/guardian(s) name: \_\_\_\_\_

Mom's work phone: (\_\_\_\_) \_\_\_\_\_ Dad's work phone: (\_\_\_\_) \_\_\_\_\_

Name of alternate who may be contacted in case of emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ Care Card Number: \_\_\_\_\_

Have you been treated for any serious illness such as epilepsy, heart disease, diabetes, etc.? No  Yes  If yes, please give details: \_\_\_\_\_

Are your immunizations up to date? No  Yes  Never immunized

If no, what is needed? \_\_\_\_\_

Date of last tetanus immunization \_\_\_\_\_ / \_\_\_\_\_  
month year

Do you have any allergies / food allergies? No  Yes  If yes, please detail: \_\_\_\_\_

Explain reaction and indicate medication used (medication should be brought with you).  
\_\_\_\_\_

Do you carry an EpiPen? No  Yes

Do you suffer from asthma? No  Yes  mild  medium  severe   
Please give detail: \_\_\_\_\_

Will you be taking prescription medication during your time at camp? No  Yes   
If yes, please specify the name(s) of the medication(s) and the conditions(s) being treated:-  
\_\_\_\_\_

Have you ever undergone any operations or sustained any serious injuries? No  Yes   
If yes, please provide details: \_\_\_\_\_

Do you have any limitations which would affect your camp experience? No  Yes   
Please detail explaining how you deal with it and how you would like us to deal with it: \_\_\_\_\_

*We will always do everything possible to contact parents or guardians in case of accident or illness. It may be necessary to get immediate medical attention for you and it may not be possible to contact your parents prior to doing so. Your parent's signature on the following 'permission clause', will allow us to get immediate medical help should it be necessary.*

This section to be filled out by applicant or parent(s)/guardian(s) if applicant is under the age of 19.

I verify that the above medical information on myself or 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 parents will be notified as soon as possible in case of any emergency affecting their children. In the event that I cannot be reached in an emergency, I hereby authorize the calling of a physician to provide whatever emergency medical or surgical treatment is necessary.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
*Signature of Applicant or Parent or Guardian*