Camp Fire Wilani
380 Q Street, Suite 260
Springfield, Oregon 97477
541-342-6338
wilanicouncil.org

Camp Fire Wilani

Adult Health History

Part 1: Adult information

Adult Name: Birth Date: ☐ Female ☐ Male Non-Binary

Address/City/Zip: Email:

Day Phone: Evening Phone: Cell Phone:

Health Information Privacy Statement

The Adult Health History Record is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor of the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. The health history record will be retained by the council until it is destroyed. All forms/records with noted treatment will be retained for seven years. Access to the information will be limited, but copies may be requested from the council by the participant or their legal representative.

I have read the above procedures for handling the health history record information and I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Adult Participant Signature: **Date:**

Part 2: Insurance Information

Name of Dentist: Phone #:

Name of Doctor: Phone #:

Insurance Carrier Name: Policy/Group Number:

Part 3: Allergies/Illnesses/Injuries

Allergic Reactions: (Check those that Apply and specify nature of the allergic reaction) ☐ Check here for no known allergies

☐ Animals ☐ Hay Fever ☐ Medicines/Drugs ☐ Pollen
☐ Food ☐ Insect stings ☐ Plants ☐ Other (specify)

Chronic or Recurring Illnesses: (Check those that apply and give appropriate dates)

☐ Arthritis ☐ Asthma ☐ Diabetes ☐ Dizziness
☐ Heart Defect/Disease ☐ Bleeding/Clotting Disorders ☐ Ear Infection ☐ Fainting
☐ Hypertension ☐ Menstrual Problems ☐ Musculoskeletal Disorder ☐ Seizures

Date of last health examination:

Were any complicating medical problems noted? ☐ Yes ☐ No

If yes please explain:

Other health conditions or injuries that might impact your participation?

Part 4: Medication

Are you taking any medications? ☐ Yes ☐ No

If YES, list medication, reason, and possible side effects

Medication	Possible Side Effects

Part 5: Consent to Treat

In the event of an emergency, every effort will be made to contact an emergency contact. I hereby give authorization to Camp Fire Wilani to seek treatment for myself by a licensed physician. I know of no reason(s), other than the information indicated on this form, why I should not participate in prescribed activities.

Adult Participant Signature: **Date:**

Part 6: Emergency Contact(s)

Name	Relationship	Cell Phone	Day Phone	Evening Phone

Please review the information on this form annually. If there are no changes or just minor adjustments, please mark those, then sign and date this form where indicated

Signed:	Date:
Signed:	Date:
Signed:	Date:
Signed:	Date:
Signed:	Date: