Youth Participant Health Form

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

PARTICIPANT INFORMATION

Participant Name _____
Last First Middle

Home Address _____
Street Address City State Zip

Birth Date _____/_____/_____ Age _____ Gender Female ☐ Male ☐ Nonbinary ☐

Parent/Guardian Name _____ Phone _____

Home Address _____
(if different from above) Street Address City State Zip

Second Parent/Guardian Name _____

Home Address _____
(if different from above) Street Address City State Zip

If neither parent/guardian is available in an emergency, notify _____

Relationship to Participant _____ Phone _____

Home Address _____
Street Address City State Zip

INSURANCE INFORMATION
Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If yes, please indicate carrier or plan name _____ Group # _____

➔ Photocopy of front and back of health insurance card must be attached to this form.

PARENT/GUARDIAN AUTHORIZATIONS:
This health history is correct and complete as far as I know, and the person herein described has permission to engage in all club activities except as noted.
I hereby give permission to Camp Fire Wilani staff/volunteers to seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes. I give permission to Camp Fire Wilani staff/volunteers to arrange necessary related transportation for me/my child. In the event I cannon be reached in an emergency, I hereby give permission to the physician selected by Camp Fire Wilani to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied field for trips.

Signature of parent or guardian _____

Printed name _____ Date _____

ALLERGIES (list all known, list any more on a separate sheet)
Medications: Food: Other:
_____ _____ (including insect stings, asthma, etc.)

_____ _____ _____
_____ _____ _____
_____ _____ _____

MEDICATIONS BEING TAKEN

Please list ALL medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire time at camp. Keep it in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medication** on a routine basis **OR** ☐ This person **takes medications** as follows:

Medication #1 _____ Dosage _____ Time of day taken _____

Reasons for taking _____

Medication #2 _____ Dosage _____ Time of day taken _____

Reasons for taking _____

Attach additional pages for more medications. Also, please identify any medication taken during the school year that participant does/may not take at club meetings/on field trips _____

RESTRICTIONS (The following restrictions apply to this individual)

Does not eat: ☐ Red Meat ☐ Pork ☐ Dairy Products ☐ Poultry ☐ Seafood
☐ Eggs ☐ Other: _____

Explain any restrictions to activity (e.g. what cannot be done, what adaptations or limitations are necessary)

_____

_____

GENERAL QUESTIONS

Has/does this participant:	YES	NO		YES	NO
1. Had any recent injury, illness, or infectious disease?	☐	☐	16. Ever had back problems?	☐	☐
2. Have a chronic or recurring illness/condition?	☐	☐	17. Ever had problems with joints (e.g. knees, ankles)?	☐	☐
3. Ever been hospitalized?	☐	☐	18. Have an orthodontic appliance being brought to camp?	☐	☐
4. Ever had surgery?	☐	☐	19. Have any skin problems (e.g. itching, rash, acne)?	☐	☐
5. Have frequent headaches?	☐	☐	20. Have diabetes?	☐	☐
6. Ever had a head injury?	☐	☐	21. Have asthma?	☐	☐
7. Ever been knocked unconscious?	☐	☐	22. Had mononucleosis in the past 12 months?	☐	☐
8. Wear glasses, contacts or protective eyewear?	☐	☐	23. Had problems with diarrhea/constipation?	☐	☐
9. Ever had frequent ear infections?	☐	☐	24. Have problems with sleepwalking?	☐	☐
10. Ever passed out during or after exercise?	☐	☐	25. If female, have an abnormal menstrual history?	☐	☐
11. Ever been dizzy during or after exercise?	☐	☐	26. Have a history of bed-wetting?	☐	☐
12. Ever had seizures?	☐	☐	27. Ever had an eating disorder?	☐	☐
13. Ever had chest pain during or after exercise?	☐	☐	28. Ever had emotional difficulties for which		
14. Ever had high blood pressure?	☐	☐	professional help was sought?	☐	☐
15. Ever been diagnosed with a heart murmur?	☐	☐			

Please explain any "yes" answers, noting the number of the questions _____

_____

Which of the following has the participant had?

☐ Measles
☐ Chicken Pox
☐ German Measles
☐ Mumps
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C

TB Mantoux Test
Date of last test: _____
Result: ☐ Positive ☐ Negative

Please give all dates of immunization for:

Vaccine: Dates:	M/Y	M/Y	M/Y	M/Y	M/Y	M/Y
DTP	_____	_____	_____	_____	_____	_____
TD (tetanus/diphtheria)	_____	_____	_____	_____	_____	_____
Tetanus	_____	_____	_____	_____	_____	_____
Polio	_____	_____	_____	_____	_____	
MMR	_____	_____				
or Measles	_____	_____				
or Mumps	_____	_____				
or Rubella	_____	_____				
Haemophilus influenza B	_____	_____	_____	_____		
Hepatitis B	_____	_____	_____			
Varicella (chicken pox)	_____	_____				

Use this space to provide any additional information about the participant's behavior and physical, emotional, or mental health about which the camp should be aware: _____

_____

Name of family physician _____ Phone _____
Address _____