# HEALTH INFORMATION FORM – SPECIAL NEEDS CAMPOREE

**COMPLETE AND RETURN WITH REGISTRATION IN A SEALED ENVELOPE WITH THE PARTICIPANT'S NAME CLEARLY PRINTED ON THE FRONT. ALL PARTICIPANTS MUST HAVE A COMPLETED HEALTH FORM.**

PLEASE PRINT

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Name _____Male ☐ Female ☐

Address_____

City, State, Zip_____

Date of Birth _____Age _____ Home Phone _____Wk Phone_____

Name and Address of person to notify in case of emergency:_____

_____

Daytime phone _____Relationship to Child _____

ALLERGIES (Check if yes)
( ) Hay Fever ( ) Asthma ( ) Insect Bites ( ) Ivy, Oak, etc.

Foods:_____Drugs_____

Has now or often has (check if yes):

| | | |
|---|---|---|
| ( ) Heart Disease | ( ) Diabetes | ( ) Convulsions |
| ( ) Breathing Difficulties | ( ) Stomach/Digestion Problems | ( ) Hearing Difficulties |
| ( ) Vision Impairment | ( ) Speech Impairment | ( ) Ear Infections |

Condition requiring medications? ( ) Yes ( ) No

List:_____

Medication:_____Dosage_____

Restricted Activities for Medical
Reasons:_____

**Permission:** **Hiking** ( ) Yes ( ) No **Running** ( ) Yes ( ) No **Fishing** ( ) Yes ( ) No

IMMUNIZATIONS – List Date of Last Inoculation

| | |
|---|---|
| Tetanustoxoid _____ | Measles _____ |
| Polio _____ | Mumps _____ |
| Diphtheria _____ | German Measles _____ |
| D.P.T. _____ | MMR _____ |

Signature if 18 or older:

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This form must be signed by a parent or legal guardian if under 18. No one but the father, mother, or a legal guardian can legally give permission for treatment of a minor. Please be assured that in the event of an emergency, every effort will be made to contact the person named above as the emergency contact.

AUTHORIZATION TO TREAT A MINOR

**I, (parent/guardian's name) _____, authorize the North Florida Council, Learning for Life, Inc. to approve emergency medical treatment for (child's name)_____.**

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Special Instructions or comments:

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