

# ADULT HEALTH FORM

VALID FROM \_\_\_\_\_ TO \_\_\_\_\_



*“Camp Fire USA builds caring, confident youth and future leaders.”*

**PRINT CLEARLY – USE BLACK INK ONLY – MUST BE NOTARIZED**

**I UNDERSTAND IT IS MY RESPONSIBILITY** to notify the council BEFORE scheduled activities of any change in my health and to notify the council if my emergency contact will be away from usual phone when I am participating in CAMP FIRE USA SUNSHINE COUNCIL activity.

Adult Name	Home Phone
Mailing Address	Work Phone
City                      State                      Zip	Cell/Other Phone
Place of Employment	Occupation
Male _____ Female _____	Date of Birth
Swimming Ability: Non-Swimmer _____ Beginner _____ Intermediate _____ Advanced _____ Lifeguard _____	
Doctor	Dentist
Phone	Phone

Name of Spouse	
Work Phone	Cell / Alternate Phone
Name of alternate emergency contact (other than spouse)	
Relationship	
Home Phone	Work Phone

## MEDICAL INFORMATION

DO YOU HAVE?	YES	NO	ALLERGIES?	YES	NO	If yes, to what?
Fainting			Medications			
Sleep Walking						
Restlessness						
Frequent Headaches			Insects Is medicine required?			
Nose Bleeds			Pollen			
Motion Sickness			Food			
Immunizations current			<b>DO YOU HAVE?</b>	<b>YES</b>	<b>NO</b>	<b>Please describe</b>
Tetanus inoculation current			Asthma Use inhaler?			
Birth defect, major disability, or chronic illness. If yes, please list below:			Lung Disease			
			Seizure Disorder Controlled by Meds?			
			Diabetes Take insulin?			
			Hearing Loss			

If you have had a serious accident or illness within the past twelve months or are subject to a more serious health condition or if there are any questions about activity restriction, at the discretion of the Executive Director, further information or specific information to participate in activities from a physician may be required.

In the event of any illness or accident requiring emergency treatment while involved in any Camp Fire USA activity, I hereby give my permission for any necessary hospitalization, medication, surgery or transportation on recommendation of medical personnel, staff, or the volunteer in charge, in which case all such expenses shall be paid by me. I hereby waive and release Camp Fire USA Sunshine Council, Inc., Camp Fire USA, and its employees, affiliates, volunteers and directors, and owners/operators of the facility where I am engaged in a Camp Fire USA activity (collectively referred to herein as "Releasees") from all claims, liability, loss, and damage whatsoever on account of any injury to or death of any person and from any damage to, destruction of, or loss of use of any property which at any time may be suffered or sustained by any person or entity arising as a result of any act or omission, negligent or otherwise, of Releasees or their agents, except for claims arising from gross negligence or willful acts of Releasees or their agents that may arise from participation in the activities of Camp Fire USA.

Date \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

STATE OF FLORIDA, COUNTY OF \_\_\_\_\_. The foregoing was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by \_\_\_\_\_ who is personally known to me \_\_\_\_\_ or has produced: FL Driver's License \_\_\_\_\_ Other \_\_\_\_\_ as identification, and who did not take an oath.

**Print, stamp or type name of Notary below:**

\_\_\_\_\_  
Notary Public Signature

STAFF USE: INPUT DATE \_\_\_\_\_