



BFA Jr. Balloonist Hot Air Balloon Camp Health History Form

One form for each camper / volunteer. Please print in Ink

The information in this form is to assist your camp staff in identifying appropriate care. If under 18 years of age, a parent/guardian should fill out pages 1-3. Any changes to this form should be provided to the camp staff upon check-in at camp. This form may be photocopied for your convenience.

Camper Name _____ Birthday ___/___/___ Age at Camp _____
Last First MI

Home Address _____
Street Address City State Zip

Home Phone (_____) _____ Email _____ Gender M / F

Parent/Guardian Name _____

Home Address _____
Street Address City State Zip

Phones: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Second Emergency Contact Name _____

Home Address _____
Street Address City State Zip

Phones: Home: (_____) _____ Work: (_____) _____ Cell: (_____) _____

Camper Signature: I agree to abide by any restrictions placed on my participation in camp activities by my physician, or parents/guardian as described here:

Signature of camper _____ Date _____

Parent/Guardian signatures required for attendance

Parent/Guardian Authorization: This health form contained herein is correct as far as I know and the camper has permission to engage in all camp activities except as noted. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by a designated representative of the Balloon Federation of America to authorize emergency medical or surgical treatment, routine, non-surgical medical care, hospitalize, secure proper anesthesia, or to order injection(s) for my child. The person herein described is in good health, has all required immunizations current, and I assume the health responsibility for the individual.

Health Care: I give the camp staff permission to give my child over-the-counter and prescription medications in accordance to prescribed instructions.

Emergency Authorization: I give permission to the medical personnel to order X-rays, routine tests and treatment for my child, in the event I cannot be reached in an emergency. I give permission to the medical personnel to hospitalize, secure proper treatment and to order injections and anesthesia and/or surgery for my child. This form may be photocopied for use with medical personnel.

Transportation Authorization: I give permission for my child to be transported in a private vehicle, if necessary.

Liability Release: It is understood that the activities of the camp will include crewing and tethering in hot air balloons, and travel in private vehicles. The attendees and parents undersigned release the sponsors, officials, employees, and volunteers of the Balloon Federation of America and Albion College from any and all claims or liability in connection with the events of the BFA youth balloon camp. The attendee and parents agree that this release and waiver agreement is intended to be broad and inclusive as permitted by the State of Michigan, and that if any portion thereof is held invalid, it is agreed that the balance shall continue in full legal force and effect.

Camper's Signature (if 18 or older)
Or Parent/Guardian Signature _____ Date _____

Printed Name _____

Health History

The following information must be filled in by the parent/guardian, or adult camper or staff/volunteer member.

Insurance Information: Is the camper covered by family medical/hospital insurance? Yes No

Carrier and Plan Name: _____ Policy or group number _____

Please attach a copy of your insurance card.

Describe dietary or activity restrictions: _____

Allergies	List all known	Reaction and management of reaction
Medication allergies (Penicillin, etc.)	_____	_____
Insect bites/stings	_____	_____
Food allergies	_____	_____
Other allergies	_____	_____

Medications: Check here if this person takes **no** medications on a regular basis.

List **all** medications taken on a regular basis or that camper will bring to camp. Prescription medication must be brought in original container. The dosage/frequency schedule identified by the physician will be administered by camp staff. Bring enough medication to last the entire camp session. It is not recommended that extra medication be brought to camp. Leave gray area blank for camp staff's notes.

It is recommended that all medication used during the school year is also used during camp week. Please do not use this time to test your child's routine.

Medication	Dosage	Specific time	Reason for taking
#1			
#2			
#3			
#4			
#5			
#6			

The camp staff can provide my child with these over the counter medicines if necessary:

___ Tylenol ___ Motrin/Advil ___ Tums ___ Benadryl ___ None

Are there any over the counter medications that should NOT be administered? _____

Health History

Primary Physician Name _____

Phone (____) _____

Dentist Name _____

Phone (____) _____

Medical Conditions	Circle One	Medical Conditions	Circle one
Recent injury, illness or infectious disease	Y N	Heart Defect/Disease	Y N
Chronic or recurring illness/condition	Y N	Mononucleosis in the past 12 months	Y N
Autism **	Y N	Ever had emotional difficulties for which professional help was sought	Y N
ADD or ADHD **	Y N	Bleeding/clotting disorders	Y N
Diabetes	Y N	Wears glasses, contacts or protective eye wear	Y N
Asthma	Y N	History of sleep walking	Y N
Has or had an eating disorder	Y N	Uses wheelchair or walker **	Y N
Seizures	Y N	Other:	Y N

Please assist us so we can provide the best camping experience for your child!
 If ** is indicated, please contact the camp director
 One month prior to the camp to assist us with our staff and room assignments.

Provide an explanation for all questions to which you answered Yes above or any other condition of which you feel the camp staff should be aware.

Immunization History (date of most recent immunization)

Tetanus ___/___/___ Measles ___/___/___ Polio ___/___/___
 Rubella ___/___/___ Mumps ___/___/___ Hepatitis B ___/___/___
 Diphtheria ___/___/___ TB Test ___/___/___ Pertussis ___/___/___

Result of last TB Test (circle one) Positive Negative

FOR CAMP PERSONNEL

Arrival Day Check-in

1. Emergency authorization on page one of this form signed?	Yes	No
2. Been exposed to any contagious disease in the last two weeks?	Yes	No
If yes, please explain _____		

3. Brought over the counter or prescription medications	Yes	No
Additional medication form needed to list additional meds?	Yes	No
(A camp staff member will need to record ALL medications brought to camp.)		
4. Medical/social/physical condition of which camp staff should be informed?	Yes	No
If yes, please explain _____		

Staff member's initials _____

Information received from: Mother Father Grandparent Camper Other _____

Date, if different than registration date _____