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 the person is 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.

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

Home Address ____
Street Address City State Zip

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

Primary Emergency Contact ____

Address ____
Street Address City State Zip

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

Second Emergency Contact ____

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 ________________

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 Tyler Junior 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 Texas, 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 order)
Or Parent/Guardian Signature ____ Date ____________________

Printed Name ____ Witness _________________________________

This form was notarized by _________________________________, on _____________________ in the county of

____________________, State of _________________________.

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:	

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 ______________