Hungarian Scout Association in Exteris
Külföldi Magyar Cserkészszövetség

Health Information Form
Egészségügyi Információ Űrlap

www.kmcssz.org

Troop No.:

Camp:

Name (Last, First, MI):

Date of Birth (DDMMYYY): **Age**: **Male**: ☐ **Female**: ☐

Home Address:

City: **State/Province**:

Country: **Postal/Zip Code**:

Telephone No.: **Alternate Telephone No.**:

Emergency Contact: **Relationship**:

Telephone No.: **Alternate Telephone No.**:

Alternate Emergency Contact: **Relationship**:

Telephone No.: **Alternate Telephone No.**:

Health Insurance Information Attached: Yes ☐ No ☐

Please Attach a copy of camper's insurance card(s) or insurance company information

Immunization Record: Attached: Yes ☐ No ☐

If camper is under 18 years of age, please attach a copy.

Note: State law requires that this information be accurate and complete with dates of vaccination.
Minor campers are not permitted to remain in camp if this information is incomplete!

Meningitis Vaccination: Please attach completed Form 3 (for minor campers) Attached: Yes ☐ No ☐

Physicians' Contact Information:

PCP Name: **Phone:**

Specialist: **Phone**: **Specialty**:

Are you currently being actively treated for anything? Yes ☐ No ☐

If yes, describe the condition(s):

Mandatory for campers under 18 years of age: **Form 2 attached** Yes ☐ No ☐

***Current medications, as well as medications authorized by camper's physician to be dispensed by camp staff, must be listed on Form 2 ***

List any special instructions on a separate page that camp health staff need to know to ensure camper's health in camp.

Allergies

Do you have any allergies to medications? Yes ☐ No ☐ Name them:

Do you use an epinephrine auto – injector? Yes ☐ No ☐ Explain:

Do you use an asthma rescue inhaler? Yes ☐ No ☐

Do you have allergies to:	Yes	No	Name/Type	Describe Severity (Mild, Moderate, Severe)
Insects	☐	☐		
Animals	☐	☐		
Plants	☐	☐		
Foods	☐	☐		
Other	☐	☐		

Medical History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Diabetes	
☐	☐	Asthma/Reactive Airway Disease	
☐	☐	Hypertension (High Blood Pressure)	
☐	☐	Adult or congenital heart disease/ heart attack / chest pain (angina)/ heart murmur /coronary artery disease. Any heart surgery or procedure. Explain all "yes" answers	
☐	☐	Stroke/ TIA	
☐	☐	Lung/Respiratory Disease	
☐	☐	Eyes/Ears/Nose/Sinus	
☐	☐	Muscle or Bone Disease	
☐	☐	Altitude Sickness	
☐	☐	Psychiatric/Psychological or Emotional Difficulties	
☐	☐	Neurological/Behavioral Disorders	
☐	☐	Blood Disorders	
☐	☐	Fainting Spells / Dizziness	
☐	☐	Kidney Disease	
☐	☐	Seizures or Epilepsy	
☐	☐	Abdominal/ Digestive / Stomach Problems	
☐	☐	Thyroid Disease	
☐	☐	Skin Disorders	

Medical History Continued

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
☐	☐	Obstructive Sleep Apnea / sleep disorders	
☐	☐	Surgeries / Hospitalizations	
☐	☐	Any medical condition not listed above	

Consent for Participation in Water Sports and Activities

Grant permission for camper to participate**: Yes** ☐ **No** ☐

Swimming Ability:

Non-swimmer ☐ **Beginner** ☐ **Intermediate** ☐ **Advanced** ☐

Lifeguard ☐ **Swimming Instructor** ☐

Certificate (Type):

Issuing Agency:

Expiry date (if applicable):

Please Attach a copy of the certificate.

Attachment Checklist

Please ensure that the required copies and Forms are included:

	Yes	No	Note
Meningitis Vaccination Form 3	☐	☐	
Camper Medication Order Form (OTC medications)	☐	☐	**Must be signed by camper's primary care physician**
Food Allergy Form	☐	☐	
Health Insurance	☐	☐	Copy of all applicable health insurance coverage
Immunization Record	☐	☐	
Camper Special Instructions	☐	☐	For conditions/circumstances that require special care
Swimming Certificate	☐	☐	

ACKNOWLEDGMENT AND CONSENT TO MEDICAL TREATMENT

I understand that camping involves activities that pose inherent risk, including the use of sharp tools, open fires, and strenuous physical activity. I/the above-named camper will participate in those activities voluntarily and will follow all supervisory directions.

Initial

To the best of my knowledge, I/the abovenamed camper, am/is in good health and do/does not suffer from any physical, mental, or emotional problems preventing the participation in camp activities.

Initial

Camp Health Services ("CHS") complies with all public health directives, guidelines, and recommendations, or children's camps. Specifically, CHS offers triage and first aid medical care for acute conditions only. On-going care for acute and chronic medical conditions beyond triage and first aid will not (and should not) be provided in a camp setting. Mental health concerns and behavioral issues, beyond immediate care to ensure the affected camper's safety and the safety of other campers cannot be treated or managed by CHS. In the event a camper exhibits mental health or behavioral issues, camp medical personnel will recommend that arrangements be made to return the camper to his/her home as soon as feasible under the circumstances. Any decision that a camper must leave the camp and be returned to his/her home will be made by the CHS staff in its sole and absolute discretion and will not be subject to any appeal to or redetermination by any third party.

Initial

In case of an emergency involving me or my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or adult leader.

In the event that the designated contact person cannot be reached, permission is hereby given to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child.

Initial

Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

I hereby fully release and waive any and all claims for damages, losses and related costs and expenses against the Hungarian Scout Association, its troops, leaders, volunteers, and associates, as well as its participants and agents resulting from or related to any physical or emotional harm or injury sustained by me/my child while participating in any scouting activities, or from any liability which may result from medical services administered pursuant to this consent.

Signature

Printed Name

Relationship to Camper

Date