

Night Fire Drum Line



Health and Medical

To be completed by parent or legal guardian if member is under 18 years of age

Name: _____ Date of Birth: _____ Sex: _____

Parent/Guardian: _____ Cell: (____) _____

Home Phone: (____) _____ Workplace: _____ Phone: (____) _____

If the person above cannot be contacted in the event of an emergency, notify:

Name: _____ Relationship: _____ Phone: (____) _____

Name: _____ Relationship: _____ Phone: (____) _____

Medical Information

Have you ever, or do you have:

Yes/No

___ Arthritis

___ Asthma

___ Back Problems

___ Blood Disease

Yes/No

___ Breathing Disorder

___ Carpal Tunnel Syndrome

___ Diabetes

___ Epilepsy

Yes/No

___ Glasses/Contact

___ Heart Conditions

___ Migraines

___ Knee or Ankle
problems

Any other medical conditions that may hamper your participation:

Do you have any allergies to foods, medications, or insect bites? If so please list them here:

Immunizations:

Tetanus: _____ Polio: _____ MMR: _____ Diphtheria: _____ Pertussis: _____

In case of an emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery, injections of medication, or any other necessary care for my son or daughter.

Date: _____

Signature of Parent or Guardian (if under 18) or Registered Member (if over 18)

Physician: _____ Medical Facility/City: _____

Insurance Company: _____ Policy #: _____