

**Chickagami Lodge 180  
Order of the Arrow**

**Name** \_\_\_\_\_ / \_\_\_\_\_ **D.O.B.** \_\_\_\_/\_\_\_\_/\_\_\_\_  
*Last First*

**Name of Parent or Guardian**

\_\_\_\_\_/\_\_\_\_\_  
*Last First*

**Address**

\_\_\_\_\_  
*Street*  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*City State Zip*  
(\_\_\_\_\_)\_\_\_\_\_/ (\_\_\_\_\_)\_\_\_\_\_  
*Home Phone Cell Phone*

**CHECK ALL ITEMS THAT APPLY TO YOUR HEALTH HISTORY. EXPLAIN "YES" ANSWERS**

**ALLERGIES: Food, medicines, insects, plants**

**Yes**\_\_\_ **No**\_\_\_ **Explain**\_\_\_\_\_

**GENERAL INFORMATION:**

<b>ADHD</b>	<b>Yes</b> ___ <b>No</b> ___	<b>CONVULSIONS/SEIZURES</b>	<b>Yes</b> ___ <b>No</b> ___
<b>ASTHMA</b>	<b>Yes</b> ___ <b>No</b> ___	<b>DIABETES</b>	<b>Yes</b> ___ <b>No</b> ___
<b>DIABETES</b>	<b>Yes</b> ___ <b>No</b> ___	<b>HIGH BLOOD PRESSURE</b>	<b>Yes</b> ___ <b>No</b> ___

**LIST ANY MEDICINES THAT NEED TO BE TAKEN AT CAMP**

**LIST ANY PHYSICAL CONDITIONS THAT MAY AFFECT WORK**

**NAME OF PERSONAL PHYSICIAN**

**PERSONAL HEALTH/ACCIDENT INSURANCE CARRIER**

**PARENT AUTHORIZATION:**

The health history is correct so far as I know, and the person herein described has permission to participate in OA activities. In the event of illness or accident in the course of this activity, I request that measures be instituted without delay as the judgment of medical personnel dictates. I release all the right to all photos taken to be used for OA promotions.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
*Parent or guardian*