



# DELAWARE STATE FIRE SCHOOL

2024 JUNIOR FIRE  
ACADEMY

JUNE 24th - 27th  
9AM - 4 PM

**AGES 13-17  
LUNCH PROVIDED**

**NO FIRE DEPT. AFFILIATION NEEDED**

**REGISTRATION CLOSES MAY 1ST  
OR  
WHEN ALL 50 SLOTS ARE FULL.**

**APPLICATIONS CAN BE FOUND ON OUR WEBSITE  
[WWW.STATEFIRESCHOOL.DELAWARE.GOV](http://WWW.STATEFIRESCHOOL.DELAWARE.GOV)**

# Delaware State Fire School - *Payment Information*

COMPLETE FORM, PRINT TO OBTAIN AUTHORIZED SIGNATURES, AND RETURN TO DELAWARE STATE FIRE SCHOOL BEFORE DEADLINE.



**2024 Junior Fire Academy:** REGISTRATION DEADLINE: May 1, 2024

**Course Name:** 2024 Junior Fire Academy  
**Date(s) Attending:** June 24-27, 2024  
**Class Time:** 9am-4pm each day  
**Class Location:** Delaware State Fire School Dover  
**Shirt Size:** Child L Adult S Adult M Adult L Adult XL  
**Shorts Size:** Child L Adult S Adult M Adult L Adult XL

**Comments:**

Delaware State Fire School  
1461 Chestnut Grove Road  
Dover, DE 19904  
Phone: 302-739-4773  
Fax: 302-739-6245  
www.statefireschool.delaware.gov  
Email: Fire.School@delaware.gov  
Rev. 11/18/15

## Attendee Information

**Child's Name:**

**Child's Date of Birth:**

**Parent/Guardian Name:**

**Primary Contact #:**

**Primary Address:**

**City, State, Zip:**

**Secondary Contact:**

**Secondary Contact #:**

## Payment Information

**Tuition:**

Check payable to Delaware State Fire School

Credit Card Select Type:

**Card Number:**

**Expiration Date:**

**Security Code (CVV):**

**Cardholder Name:**

**CARDHOLDER SIGNATURE:** The I authorize the Delaware tate Fire School to charge the amount listed above to the credit card provided herein.  
I agree to pay for this purchase in accordance with the issue bank cardholder agreement.

\_\_\_\_\_ **CARDHOLDER SIGNATURE**

\_\_\_\_\_ **Date**

**DELAWARE STATE FIRE SCHOOL CAMP APPLICATION**

1461 Chestnut Grove Rd, Dover, DE 19904 302-739-4773

**Junior Firefighter Academy (June 24-27, 2024)**



**CAMPER INFORMATION**

Camper Name (Last Name, First Name)		Date of Birth	Age
Primary Address	City	State	Zip
Parent or Guardian	Primary Phone	Secondary Phone	
Parent or Guardian	Primary Phone	Secondary Phone	
-			

**EMERGENCY CONTACT INFORMATION**

Primary Emergency Contact Name	Relationship
Primary Phone	Secondary Phone

**CAMPER HEALTH INSURANCE INFORMATION**

(In case of illness or injury during the camp requiring a hospital visit)

Policy Holder's Name	Insurance Company Name
Policy Number	Group Number
Insurance Company Address	Insurance Company Phone

Copy of Insurance Card requested but not required with application.



CAMPER NAME \_\_\_\_\_

**CAMPER MEDICAL HISTORY**

Please complete the following and provide any explanation on medical conditions we should be aware of:

- Non-Insulin or Insulin Dependent Diabetes
- Heart Problems/Defects or Hypertension
- Asthma or Respiratory Problems
- Musculoskeletal Problems
- Convulsions/Seizures/Epilepsy
- Fainting Spells
- Emotional Problems or Mental/Psychological Disorders
- Nosebleeds
- Headaches/Migraines
- Bleeding Disorders
- Eating Disorders
- Significant Surgery or Hospitalization within the past year
- Recent Communicable Illness (Influenza, Chicken pox, etc.)
- Any Physical Restrictions
- Other: 

--

**ALLERGIES** (Medicinal or environmental)

Allergy	Reaction/ Sensitivity	Treatment	Date of Last Reaction (if any)
1			
2			
3			
4			

Does your child suffer from Anaphylaxis and carry an Emergency Epinephrine Injector?

Yes No

Does your child suffer from Asthma/COPD and carry an Emergency Rescue Inhaler.

Yes No

Does your child require regular medication to be taken during the hours of the camp?

Yes No

If yes, please list below

Medication	Purpose	Dosage Schedule	Instructions	Camper Self Medicates?
1				Yes No
2				Yes No
3				Yes No
4				Yes No
5				Yes No
6				Yes No

I give the Staff of the Delaware State Fire School Camps permission to assist with medication administration if required by my child.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_





**CAMPER NAME** \_\_\_\_\_

If needed, the Camper has permission to take the following over-the-counter medications if available:

- Tylenol Acetaminophen
- Aspirin
- Ibuprofen
- Benadryl/Antihistamine
- Robitussin/Cough medicine
- Sudafed/Decongestant
- Pepto Bismol
- Tums/Antacid
- Skin Ointments (in case of rash, etc.)
- Other:

Does you Camper have a Special medical or dietary regiment that is to be followed?

Yes No

If yes, please explain:

**DELAWARE STATE FIRE SCHOOL CAMP APPLICATION MEDICAL EXAMINATION**

This sections is to be completed by a physician after reviewing the camper health history with the parent/guardian. The Parent Guardian must complete all of the Health History information to the best of their knowledge, before meeting with the licensed professional.

Medical Examination - Must be completed in detail

Height: \_\_\_\_\_ lbs.      Weight: \_\_\_\_\_ in BP \_\_\_\_\_      Hearing?      Left: S NS NE      Right: S NS NE

Vision? S NS NE      Vision Correction with Glasses/Contacts?      Yes No

Ears, Nose, Throat? S NS NE      Abdomen? S NS NE      Urinalysis? S NS NE

Extremities? S NS NE

Key: S = Satisfactory    NS = Not Satisfactory    NE = Not Examined

**Immunization History**

	Completed	Year		Completed	Year
Hep B	Yes or No	_____	Typhoid	Yes or No	_____
Dtap/Tdap	Yes or No	_____	Paratyphoid	Yes or No	_____
DT/Td	Yes or No	_____	Cholera	Yes or No	_____
Hib	Yes or No	_____	Yellow Fever	Yes or No	_____
IPV/OPV	Yes or No	_____	Typhus	Yes or No	_____
PCV7	Yes or No	_____			
Personal or Religious beliefs dictate against immunizations?				Yes	No

DELAWARE STATE FIRE SCHOOL CAMP APPLICATION MEDICAL EXAMINATION (cont'd)



CAMPER NAME \_\_\_\_\_

**PHYSICIAN COMPLETING MEDICAL EXAMINATION**

Licensed Physician Name: (Last, First, Middle Initial)		Office Phone Number:	
Office Address:	City:	State:	Zip:

This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities, except as noted below.

Signature of Licensed Physician: \_\_\_\_\_

State License Number: \_\_\_\_\_ Date: \_\_\_\_\_

**HEALTH INFORMATION PRIVACY STATEMENT**

The Health history and medical examination form for minors is for health care concerns at the specified event **only**. All records will be handled by staff/volunteers, whose jobs include processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff in order to provide adequate participant safety and health care. This form will be retained for seven years past the age of maturity of the participant (18 yoa). Access to the information will be limited, but copies may be requested from the event sponsor, by the participant, or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Health History and medical Examination Form for Minors is complete and accurate. My child has permission to engage in all prescribed activities, except as noted by me or the examining physician.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDIA RELEASE AUTHORIZATION**

I hereby grant the The Delaware State Fire School and all the organizations/partnerships associated with this camp permission to record my child/ward's or my (if adult participant) likeness and/or voice for use in television, films, radio or printed media to further the aims of the camp program in related campaigns and magazine articles, booklets, posters and in other ways they may see fit. **I do**                      **I do not**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**EMERGENCY CLAUSE**

In the event I cannot be reached in an emergency, I hereby give my permission to camp staff of The Delaware State Fire School and all the organizations/partnership associated with this camp to secure proper medical care for my child as deemed necessary. This permission extends from minor first aid treatment, transport to a hospital, and any necessary injections, anesthesia, surgery, or other medical procedures deemed necessary.

**I do**                      **I do not**

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_