
DELAWARE STATE FIRE SCHOOL
PRESENTS
DELAWARE
STATE FIRE SCHOOL
JUNIOR FIRE ACADEMY
2025
JUNE 23RD – 26TH
9AM TO 4 PM EACH DAY
LUNCH PROVIDED
AGES 13 TO 17
TUITION $50.00
48 SEATS AVAILABLE
SUBMIT COMPLETED
APPLICATIONS ONLY
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.

2025 Junior Fire Academy: REGISTRATION DEADLINE: May 1, 2025

Course Name: 2025 Junior Fire Academy

Date(s) Attending: June 23 - 26 2025

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: 50.00

◯ 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 _____

Click Here to Print and Fax Completed Form

DELAWARE STATE FIRE SCHOOL CAMP APPLICATION

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

Junior Firefighter Academy (June 23 - 26, 2025)

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

9Y I·ft

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: _____