Appendix C: VOLUNTEER/PARTICIPANT MEDICAL INFORMATION FORM

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Participant Home Address: _____
Street Address City State Zip Code

Parent/guardian with legal custody or emergency contact of adult participants to be contacted in case of illness or injury:

Name:_____ Relationship to Participant:_____ Preferred Phones: (_____)_____(____)

_____

Email: _____

Parent/Guardian Home Address: _____
(If different from above) Street Address City State Zip Code

Second parent/guardian or other emergency contact:

Name:_____ Relationship to Participant:_____ Preferred Phones: (_____)_____(____)

_____

Email: _____

(Optional) Additional contact in event parent(s)/guardian(s)/other contacts cannot be reached:

Name:_____ Relationship to Participant:_____ Preferred Phones: (_____)_____(____)

_____

Allergies: ☐ No known allergies. ☐ This participant is allergic to: ☐ Food ☐ Medicine ☐ The environment (insect stings, hay fever, etc.) ☐ Other
(Please describe below what the participant is allergic to and the reaction seen.)

Diet, Nutrition: ☐ This participant eats a regular diet. ☐ This participant eats a regular vegetarian diet. ☐ This participant is lactose intolerant.

☐ This participant is gluten intolerant. ☐ Other, ***please explain in space.***

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Medical Insurance Information:

This participant is covered by family medical/hospital insurance ☐ Yes ☐ No

Include a copy of your insurance card if appropriate; copy both sides of the card so information is readable.

Insurance Company_____ Policy Number_____

Subscriber_____ Insurance Company Phone Number (_____)_____

Parent/Guardian Authorization for Health Care for Participants Under the Age of 18:

This health history is correct and accurately reflects the health status of the participant **to whom it pertains. The person described has permission to participate in all event activities except as noted by me and/or an examining physician. I give permission to the physician selected by the event staff to order x-rays, routine tests, and treatment related to the health of my child for both routine health care and in emergency situations. If I cannot be reached in an emergency, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for this child. I understand the information on this form will be shared on a "need to know" basis with event staff. I give permission to photocopy this form. In addition, the event has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.**

Signature of Custodial Parent/Guardian_____ Date:_____ Relationship to Participant: _____

Chronic Concerns: *Check all that pertain to you or your child and provide information about supportive healthcare.*

_____ I have no chronic health concerns.

_____ I have the following chronic health concern(s):

- ☐ Asthma
- ☐ Headaches, Migraines
- ☐ Sleep problem
- ☐ Diabetes
- ☐ Difficulty breathing
- ☐ Fainting
- ☐ Surgical history
- ☐ Knee or ankle weakness
- ☐ Back pain or injury
- ☐ Seizure disorder: _____
- ☐ Other: _____

Immunization History:

Date (month/year) of your most recent tetanus immunization: _____

Have you completed the immunizations that were required for school attendance? . . . . . ☐ Yes ☐ No ☐N/A

VOLUNTEER/PARTICIPANT MEDICAL INFORMATION FORM

Medication: ☐ This participant will not take any daily medications while attending the event.
☐ This participant will take the following daily medication(s) while attending the event.

"Medication" is any substance a person takes to maintain and/or improve their health. This includes vitamins & natural remedies.

Please provide enough of each medication to last the entire time the participant will be at the event.

The following non-prescription medications may be stocked in the camp Health Center and are used on an as needed basis to manage illness and injury.
Cross out those the participant should not be given.

Acetaminophen (Tylenol)	Ibuprofen (Advil, Motrin)
Phenylephrine decongestant (Sudafed PE)	Pseudoephedrine decongestant (Sudafed)
Antihistamine/allergy medicine	Guaifenesin cough syrup (Robitussin)
Diphenhydramine antihistamine/allergy medicine (Benadryl)	Dextromethorphan cough syrup (Robitussin DM)
Sore throat spray	Generic cough drops
Lice shampoo or cream (Nix or Elimite)	Antibiotic cream
Calamine lotion	Aloe
Laxatives for constipation (Ex-Lax)	Bismuth subsalicylate for diarrhea (Kaopectate, Pepto-Bismol)

Is there anything else we should know regarding the participant's physical or mental health? Please explain below: