ADVENTURE TREKS

Medical Form

Last Name:

School:

Please return to: PO Box 1321 Flat Rock, NC 28731
888-954-5555 niki@adventuretreks.com Fax: 828-698-0339

THIS FORM DOES NOT REQUIRE A PHYSICAL EXAMINATION OR A DOCTOR'S SIGNATURE

Student Name_______________________________ Birth Date ____________ Age ______ Sex____
Height ____________ Weight_______________

Parent or Guardian ____
Street Address ____
City/ State/ Zip ____
Home Phone ____________________ Work Phone ____________________
Cell Phone ____________________ Email ______________________________

Second Parent or Guardian ____
Street Address ____
City/ State/ Zip ____
Home Phone ____________________ Work Phone ____________________
Cell Phone ____________________ Email ______________________________

If not available in an emergency, notify:
Name/ Relationship ______________________________ Phone ______________________
Additional Names / Phone #s____

Name of family physician:______________________________ Phone: ____________________
Name of dentist / orthodontist:______________________________ Phone:____________________

Insurance: Each participant is responsible for medical expenses.

Does the insurance company require preauthorization? Y N
Insurance Company: ______________________________ Policy #: ______________________
Billing address of Ins. Company: ____
Group #: ______________________________________ Phone:___________________________

IMPORTANT - THIS BOX MUST BE COMPLETED FOR ATTENDANCE

This health history is correct to the best of my knowledge, I believe my child to be physically and emotionally capable of participating and has permission to engage in all prescribed camp activities except as noted. **I hereby give permission to Adventure Treks, Inc. and all affiliates (including field staff and outfitters):**

1. To have access to my son / daughter's medical information included on this form.
2. To select medical personnel and to order X-rays, routine tests, or treatment for the participant listed above.
3. To make relevant medical information available to medical personnel.
4. To provide ongoing health care during the Adventure.

Emergency Authorization: In the event I cannot be reached in an emergency, I hereby give permission to the physician or dentist selected by Adventure Treks to hospitalize, secure proper treatment for and order injection and /or anesthesia and/or surgery for the participant named above. This form may be photocopied for use in the field.

Signature of parent or guardian ____

Witness ____ Date ______________________

I also understand and agree to abide by the restrictions placed on my Adventure Treks activities.

Signature of minor ______________________________________ Date ______________________

STUDENT NAME: **ADVENTURE:**

HEALTH HISTORY

Health History: *Please give approximate dates and explain in the space at the bottom of the page as needed.*

Frequent Ear Infections ____________
Chicken Pox ____________
Measles ____________
German Measles ____________
Mumps ____________
Diabetes ____________
Bleeding/ Clotting Disorders ____________
Asthma ____________
Seizures ____________
Mononucleosis ____________
Heart Defect / Disease ____________
Hypertension ____________
Autoimmune Deficiency ____________
Neck/ Back Problems ____________
Shoulder/ Wrist Problems ____________
Knee/ Ankle Problems ____________

Immunization History:

Date of last physical examination:________________

You do not need a physical or a doctor's signature to complete this form.

Date of most recent Tuberculin test: ______________________

Circle one

Is this student up to date on her / his immunizations for school? Yes No

Has this student had a Tetanus Booster in the last 3 years? Yes No Please indicate the date, if you know it. __________

Please indicate any immunization history issues we should know about: ____

____

Females:

Has this student menstruated? _______________
If not, does she know what to expect?__________
Is her menstrual history normal?______________
Any other special considerations?_____________

Has she ever suffered from severe cramps?__________
If so, what is the best treatment?__________________
____

MEDICATION

Please list any prescribed medication that is currently taken.
Please indicate what will be sent on the Adventure. If medications will be discontinued during the Adventure, please let us know.

Medication	Condition	Dosage (amount/frequency)	Side Effects

PLEASE SEND A DOUBLE SUPPLY OF ALL INHALERS AND OTHER PRESCRIPTION MEDICATIONS WITH YOUR CHILD FOR THE DURATION OF THE TRIP.

ALLERGIES

Please list any allergies including medicines, foods, plants, bites, stings, etc.

Allergy	Reactions	Medication Required

SPECIAL CONCERNS

Has this student ever required any psychiatric counseling or hospitalization? ______________________
____

Please list any operations or serious injuries (dates) ____
____

Are there any specific activities to be discouraged or limited by physician's advice?________________
____

Does your child have any specific dietary contstraints? ______________________________________
____

Please indicate any additional conditions or concerns we should know about your child. Attach extra pages if necessary.

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