

TRAILSIDE DISCOVERY HEALTH RECORD

This Form Must Be Completed and Returned

Program Name/Dates: _____

Participant Name: _____ Telephone: _____

Age: _____ Gender: Male Female Birth Date: _____ Ht: _____ Wt: _____

HOW TO REACH PARENT(S) OR LEGAL GUARDIAN

Parent/Guardian 1

Parent/Guardian 2

Home Address

Home Address

Cell Phone

Cell Phone

Business Address

Business Address

Business Phone

Business Phone

Physician's Name

Address

Phone

Hospital's Name

Address

Phone

Names, addresses, and phone numbers of person(s) who can assume responsibility for the child if the parents cannot be reached immediately in an emergency:

Person(s) authorized to take the child from the camp facility:

HEALTH HISTORY

Chicken Pox:

Mouth/Teeth Problems:

Insect or other Allergies:

Diabetes:

Orthopedic Problems:

Chronic Illness:

Seizures:

Date of last tetanus shot: _____

Hospitalizations:

Food Allergies:

Tetanus:

Emotional/Mental Illness:

Blood Disorders/Anemia:

Measles:

Eyes/Vision Problems:

Skin Conditions:

Hay Fever:

Nose/Throat Problems:

Surgeries:

Shortness of Breath, Hoarseness or Asthma:

Abdomen-Hernia:

Ears/Hearing Problems:

Drug Allergies:

Headaches, Dizziness, Fainting:

Nervous System:

Heart Disease/Chest Pain/Palpitations:

T.B. vaccination:

Constipation, Diarrhea, Salmonella, Giardia or other intestinal disorder:

Any Mental, Emotional, or Physical Disorder not listed above:

Please provide us with any details on any of the above conditions we may need to know:

Description of any current health conditions requiring medication, treatment, or special restrictions or considerations while at camp. Please provide us with details:

Is there a special Medical, Dietary regimen that should be continued? Please describe:

For programs which include an overnight experience, please check those conditions the participant has experienced:

Sleep Disturbances: Menstruation: Bed Wetting: Other: _____

Trailside Discovery Programs involve young people in active activities in a variety of outdoor settings in all kinds of weather conditions. Safety is our premier concern, but active young people will on occasion find ways to injure themselves. Are there activities which your child should not participate in due to health concerns or parental desires? Yes No

If "Yes" please give details: _____

IMMUNIZATION RECORD – I attest that all immunizations required for school are up to date and including the actual date of last tetanus shot. Initial _____ Date _____

AUTHORIZATIONS

My son/daughter/dependent has permission to participate in all Trailside activities, except as noted by me. I recognize that my child will be participating in active, outdoor programs with other children and that accidental injuries or illness may result. I assume the inherent risks including but not limited to, moose, bear, and inclement weather, and authorize my child's participation. Children will walk to local parks or be transported to wild areas around the Anchorage Bowl (or beyond in the case of the Alaskan Quest program) or by vans operated by the Trailside Discovery Program. Vans operated by Trailside Discovery are equipped with seat belts which participants are required to wear. I authorize Trailside Discovery staff members to transport my child in the manner described. On occasions, photographs of participants are used for publicity purposes or included in grant applications submitted to charitable foundations. I authorize Trailside to use photographs taken for these purposes.

Health Insurance Company: _____

Policy Number: _____

Name and telephone number of individuals physician or health care facility: _____

I HAVE READ THIS FORM, AND THE PARENT POLICY FORM. I AGREE TO ITS TERMS AS NOTED, AND I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE AND COMPLETED TO THE BEST OF MY KNOWLEDGE.

Parent/Guardian Signature

Date

Parent/Guardian Printed Name

CONSENT FOR EMERGENCY MEDICAL OR SURGICAL CARE

In the rare event of an emergency, I hereby give permission to the medical personnel selected by the camp director to provide routine health care; to administer medications; to order x-rays, routine tests, treatment; to release any records necessary for insurance purposes; and to provide or arrange necessary related transportation for me/or my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the camp director to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips out of camp. All information is strictly confidential. Trailside Discovery does not cover accident insurance coverage for participants; you must carry your own accident insurance coverage. I authorize the following information for insurance purposes.

It is understood that a conscientious effort will be made to locate me or my child's other parent or legal guardian. I understand my obligation to keep Trailside Discovery informed of my whereabouts. I will assume the cost of necessary medical or surgical care.

Parent/Guardian Signature

Parent/Guardian Printed Name

Date