Trailside Discovery Medical Form

Campers Full Name:					
DOB: _____/_____/_____	**Last Exam:** _____/_____/_____	**Grade:**	**Gender:** M / F	**Height:**	**Weight:**

Household Information

Parent 1:	DOB:	Parent 2:	DOB:
Home:	**Cell:**	**Home:**	**Cell:**
Email:		**Email:**	
Address:		**City:**	**State:** / **Zip Code:**

Emergency Contact Information

Name:	Relationship:	Home:	Cell:
Authorized Camper Pick Up:			

Health History

Immunizations

Tetanus:	Diptheria, Pertussis, Polio:	IPV/OPV:
☐ YES ☐ NO Date: ___/___/___	☐ YES ☐ NO Date: ___/___/___	☐ YES ☐ NO Date: ___/___/___
Chicken Pox: ☐ YES ☐ NO Date: ___/___/___	**Haemophilus Influenza B:** ☐ YES ☐ NO Date: ___/___/___	**TB Mantoux Test:** ☐ YES ☐ NO Positive/Negative Date: ___/___/___

Medical Conditions

- ☐ ADD/ADHD
- ☐ Back Pain
- ☐ Behavior Issues
- ☐ Ear Infections
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Problems
- ☐ High Blood Pressure
- ☐ Homesickness
- ☐ Kidney Disease
- ☐ Menstrual Difficulties
- ☐ Mental Health Issues
- ☐ Other_____

_____

Explain checked conditions:

_____

_____

_____

Allergies, Restrictions, & Injuries

1) **Does your child require an EpiPen?** ☐ YES ☐ NO
(Yes) Date and description of the last reaction: _____
_____

2) **Does your child have any dietary restrictions?** ☐ YES ☐ NO
(Yes) Explain: _____
_____

3) **Surgeries, hospitalizations, or injuries we should be aware of?** ☐ YES ☐ NO
(Yes) Explain with date of incident(s): _____
_____

4) **Does your child require any special accommodations?** ☐ YES ☐ NO
(Yes) Explain: _____
_____

5) **Has your child been exposed to any communicable diseases within the last 3 months?** ☐ YES ☐ NO
(Yes) Explain Disease(s) and date of exposure: _____
_____

6) **Does your child have any activity restrictions?** ☐ YES ☐ NO
(Yes) Explain along with accommodations: _____
_____

7) **Please list any other medical information the camp should have:** _____
_____

Trailside Discovery/921 W 6th Suite 200 Anchorage, AK 99501/907-274-5437(KIDS)/trailside@akcenter.org

Health Insurance

Policy Holder Information

Full Name:	**Contact Number:**
Insurance Company:	**Ins. Contact Number:**
Group Name/Number:	**Policy Number:**

Family Doctor

Clinic Name:	**Contact Number:**
Physician Name:	

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 the Trailside Discovery Program 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 authorized Trailside to use photographs taken for these purposes.

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, included hospitalization, for my child. This completed form may be photocopied or printed 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.

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

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.

Legal Guardian Signature:

Date: _____

ALASKA CENTER FOR THE ENVIRONMENT
Trailside Discovery

Thank you,
Thomas Burek
Thomas Burek
Trailside Camp Director

american CAMP association ACCREDITED

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