Medical & Health Forms

This form is to be completed by the parent/guardian for all children attending a _____ (program name) outdoor and/or overnight activity. The information requested on this form is intended to help provide information on any pre-existing medical conditions so that in case of an emergency you have provided us with accurate information about your child. This information will be kept in strict confidence.

GENERAL INFORMATION

Participant's Name: _____

Date of Birth: _____ Grade: _____ School: _____

Sex assigned at birth: ☐Female ☐Male ☐Prefer not to say

Name of Parent(s)/Guardian: _____ Phone #: _____

_____ Phone #: _____

Alternate Emergency Contact: _____ Phone #: _____

Health Insurance Carrier: _____ Policy #: _____

MEDICAL INFORMATION

1. Allergies (including medicines, foods, bites, stings). List below (use back of page if necessary)

☐ NONE

If yes, please list allergy type, reaction and medication & required dosage:

_____

_____

2. Medication (including over the counter and/or prescribed medication).

☐ NONE

If yes, please list medication(s), condition, dosage (amount/frequency), and side effects:

_____

_____

Medication administration: elementary school-aged participants must not self-administer their prescription medication, except in certain circumstances approved in advance by the Program Coordinator. Middle and high school-aged participants may self-administer their prescription medication, unless it is a controlled substance, or in other circumstances where self-administration is not appropriate or advisable. If parents do not feel confident that their child can self-administer their medication, they can request special accommodations, in which case chaperones may assist the participant with administration if appropriate and approved in advance by the Program Coordinator. Please contact the Program Coordinator in advance of the trip to discuss special accommodation options.

☐ My child is middle or high school-age and is authorized to self-administer the above-described prescription medication.

☐ My child will require assistance and special accommodations to administer the above-described prescription medication.

3. Current medical (physical, emotional, mental) conditions that we should be aware of (examples include diabetes, asthma, epilepsy, high blood pressure, heart disease, pulmonary disease, cancer, medication dependent depression or anxiety). List below (use back of page if necessary)

☐ NONE

If yes: please list condition, severity of condition, and year diagnosed:

_____

_____

4. Other pertinent information (phobias, sensitivities, behaviors, special needs, etc.)

☐ NONE

If yes, please list below:

_____

_____

5. Health Profile (check and describe below):

	Yes	No
1. Pregnant	☐	☐
2. Seizure within past year	☐	☐
3. Hospitalization/emergency room visits within past year	☐	☐
4. Neck/back/shoulder/knee/ankle problem	☐	☐
4. History of cardiac conditions	☐	☐

If marked 'yes' to any of the above, please detail below, including symptoms/restrictions (use back of page if necessary).

6. If your child is currently seeing or has not yet seen a Licensed Health Care Provider (LHCP) for any of the above medical information provided in sections 1-5, Knik Tribe suggests receiving a recommendation from a LHCP prior to participating in this program. If your LHCP would like more information about the program, they may call:

(Program Coordinator, Title, Phone Number)

Name of Licensed Health Care Provider:

Profession:

Recommendation:

7. Additional Information

If necessary, attach an additional sheet to provide more information on any of the above sections (Medical Information Sections 1-6).

Additional Sheet Provided? ☐YES ☐ NO

ACKNOWLEDGEMENT:

As a parent or guardian, I understand and acknowledge that my failure to disclose relevant information may result in harm to my child and/or others during this trip. By signing my name, I represent that I have provided all important information relating to my child's medical, mental, and physical condition, that my child does not have any conditions that would limit or prevent their participation in the trip, and that this information is accurate and complete to the best of my knowledge.

I understand and acknowledge that while on the trip, my child may be taken to rural areas with little to no access to medical care and that there are no Licensed Health Care Providers accompanying the trip group. I understand that this trip entails risks, including the risk of injury or death. I have weighed these risks and determine that the trip is appropriate activity for my child, and I acknowledge and assume all of the risks associated with my child participating in the trip.

In case of emergency, illness, or accident to my child while on the trip, I give consent to the nearest hospital to render medical emergency care deemed appropriate by the hospital staff. In such an emergency, I also give consent to trip personnel to take action deemed necessary in their judgement for the health of my child, including disclosure of the medical information provided on this form to a health care provider. I release the Knik Tribe and/or trip personnel from any and all claims related to incorrect or incomplete medication administration, the administration of first aid or medical treatment, or the failure to administer first aid or medical treatment, related to my child's participation in this trip.

Parent/Legal Guardian: _____ Date: _____

Over the Counter Medicine Release Form – Minor

Child's Name: _____ Date: _____

Non-Consent
Sign here only if you do not want any form of over-the-counter medications given to your child.

_____ _____
Parent/ Legal Guardian Signature Date

_____ _____ _____
Cell Phone Work Phone Home Phone

Consent
The following medications may be administered to my child while they are on a _____ (program name) outdoor and/or overnight activity:

Acetaminophen (Tylenol) ☐Yes ☐ No
Pain reliever, anti-inflammatory, menstrual cramps, fever reduction.
If Yes:
My child has used this before ☐Yes ☐No
My child has had a reaction to this medication ☐Yes ☐No
If yes, please give details of the reaction: _____

Ibuprofen (Advil, Motrin) ☐Yes ☐ No
Pain reliever, anti-inflammatory, menstrual cramps, fever reduction.
If Yes:
My child has used this before ☐Yes ☐No
My child has had a reaction to this medication ☐Yes ☐No
If yes, please give details of the reaction: _____

Diphenhydramine (Benadryl) ☐Yes ☐ No
Antihistamine, given for bug bites, bee stings or minor allergic reactions.
If Yes:
My child has used this before ☐Yes ☐No
My child has had a reaction to this medication ☐Yes ☐No
If yes, please give details of the reaction: _____

KNIK TRIBE

Anti-itch gel, cream or lotion ☐Yes ☐No

Itch relief for poison oak and bug bites.

If Yes:

My child has used this before ☐Yes ☐No

My child has had a reaction to this medication ☐Yes ☐No

If yes, please give details of the reaction: _____

Upset stomach / antidiarrhea ☐Yes ☐No

(GasX, Tums, Pepto-Bismol.)

If Yes:

My child has used this before ☐Yes ☐No

My child has had a reaction to this medication ☐Yes ☐No

If yes, please give details of the reaction: _____

Antibiotic ointment (Neosporin) ☐Yes ☐No

To prevent cuts from becoming infected

If Yes:

My child has used this before ☐Yes ☐No

My child has had a reaction to this medication ☐Yes ☐No

If yes, please give details of the reaction: _____

Insect Repellent with deet ☐Yes ☐No

without deet ☐Yes ☐No

To prevent bug bites

If Yes:

My child has taken this before ☐Yes ☐No

My child has had a reaction to this medication ☐Yes ☐No

If yes, please give details of the reaction: _____

Meclizine HCI, 25mg ☐Yes ☐No

Motion Sickness Relief

If Yes:

My child has taken this before ☐Yes ☐No

My child has had a reaction to this medication ☐Yes ☐No

If yes, please give details of the reaction: _____

Sunscreen ☐Yes ☐No

To prevent sunburn

If Yes:

My child has taken this before ☐Yes ☐No

My child has had a reaction to this medication ☐Yes ☐No

If yes, please give details of the reaction: _____

Cough Syrup or drops ☐Yes ☐No

If Yes:

My child has taken this before ☐Yes ☐No

My child has had a reaction to this medication ☐Yes ☐No

If yes, please give details of the reaction: _____

_____ _____

Signature Parent/ Legal Guardian Signature Date

_____ _____ _____

Cell Phone Work Phone Home Phone