

Medical and Emergency Form – School Year Programs



girlventures
Outdoor adventures for inner discovery

Program _____ Month/Year _____

PART 1 – EMERGENCY & INSURANCE INFORMATION

Applicant Name _____ Date of Birth _____ Age _____
 Address _____ City _____ Zip _____
 Home Phone _____ Participant Cell _____
 Height _____ Weight _____ Shoe size: _____
Parent/Guardian 1 _____ **Parent/Guardian 2** _____
 Phone (cell) _____ Phone (cell) _____
 Home _____ Home _____
 Work _____ Work _____

EMERGENCY CONTACT – in addition to parent/guardians listed above

| | |
|----------------------|--------------------|
| Name _____ | Relationship _____ |
| Phone 1 (Cell) _____ | Phone 2 _____ |

Medical Insurance Carrier:

| | |
|---------------------|----------------------|
| Carrier Phone _____ | Policy/ID # _____ |
| Doctor's Name _____ | Doctor's Phone _____ |

Families are responsible for medical expenses. Medical insurance is recommended but not required.

PART 2 – PERSONAL MEDICAL HISTORY

| Dietary Restrictions (Vegetarian, vegan, lactose intolerant, etc.; please describe restrictions): | | | |
|--|------------------------|--|-----------------------|
| | | | |
| Allergies (including medicines, foods, bites, stings) <input type="checkbox"/> YES <input type="checkbox"/> NO (if yes, complete below) | | | |
| Allergy | Reactions | Date of Reaction | Medication |
| | | | |
| | | | |
| Medications | | | |
| Condition | Dosage (amt/frequency) | Side Effects | Prescribing Physician |
| | | | |
| | | | |
| Asthma: | | | |
| Does participant have asthma? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Has she ever had an asthma attack? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| IF YES – YOU MUST FILL OUT AN ASTHMA EVALUATION | | | |

Medical Conditions For each of the following, check YES or NO. If YES, explain below.

| | YES | NO | | YES | NO | | YES | NO |
|--------------------|--------------------------|--------------------------|------------------------------------|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| eyes | <input type="checkbox"/> | <input type="checkbox"/> | lungs | <input type="checkbox"/> | <input type="checkbox"/> | medical equipment | <input type="checkbox"/> | <input type="checkbox"/> |
| contact lenses | <input type="checkbox"/> | <input type="checkbox"/> | asthma | <input type="checkbox"/> | <input type="checkbox"/> | recent surgery | <input type="checkbox"/> | <input type="checkbox"/> |
| ears/hearing | <input type="checkbox"/> | <input type="checkbox"/> | recent broken | <input type="checkbox"/> | <input type="checkbox"/> | restrictions to | <input type="checkbox"/> | <input type="checkbox"/> |
| neck/shoulders | <input type="checkbox"/> | <input type="checkbox"/> | bone | <input type="checkbox"/> | <input type="checkbox"/> | strenuous activity | | |
| seizure/epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | back problems | <input type="checkbox"/> | <input type="checkbox"/> | heart palpitations | <input type="checkbox"/> | <input type="checkbox"/> |
| dizziness/fainting | <input type="checkbox"/> | <input type="checkbox"/> | Pregnant | <input type="checkbox"/> | <input type="checkbox"/> | heart murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Hospitalization/ emergency room | <input type="checkbox"/> | <input type="checkbox"/> | shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| knee/ankle | | | visit w/in past year | | | | | |

Explain YES answers here:

Any other illnesses or medical condition that could affect participation on this course:

Give detailed description, including symptoms, dates (if relevant), treatment and any restrictions

| | | |
|--|-------|--|
| Therapy/Counseling ** (see below) | | |
| Is the participant currently in therapy or seeing a counselor? | | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Has the participant been to a therapist/counselor within the last 2 yrs? | | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Explain: | | |
| If counseling was terminated, when was it terminated? | | |
| Why? | | |
| Name of Therapist/Counselor | Phone | Email |

PART 3 – SIGNATURE AND AGREEMENT

****All information will remain confidential. Participants with medical/psychological issues can successfully complete the program, but we need to be aware of these conditions.** Failure to disclose such information could result in harm to you/her and your/her fellow students. Please let us know about anything which might affect your/her participation in the course.

Consent is hereby given for the applicant to attend a GirlVentures program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment, which might become necessary.

If participant arrives at the program start with a pre-existing condition or injury which is not indicated on the medical form and you/she are subsequently forced to leave because of that condition, you will be charged an evacuation fee and will not receive a refund of tuition.

Participant's Signature

Date

Parent/Guardian Signature

Date