Medical and Emergency Form – Summer Programs

Program____________________________ Month/Year__________________

Please Note: This form has 4 parts
Part 3 Requires a Visit to the Doctor & Part 4 Requires Guardian Consent and Signatures.
APPLICANTS CANNOT BE ACCEPTED UNTIL WE RECEIVE THIS FORM SIGNED BY A DOCTOR & THE GUARDIAN
PLEASE MAKE AN APPOINTMENT ASAP - DELAY MAY AFFECT APPLICANT'S STATUS.

We will determine the status of applicant's participation following our review of this information. Further questions and/or a follow-up examination by a physician, therapist, or other caregiver may be necessary. All information on this form is confidential and will only be shared with GirlVentures Staff and instructors.

PART 1 – EMERGENCY & INSURANCE INFORMATION

Applicant Name______________________________ Date of Birth ___________ Age ___________
Address _____________________________________ City ___________________ Zip___________
Home Phone __________________________________ Participant Cell ____________________________
Height _____________ Weight ___________ Participant Email: ___________________________
Parent/Guardian 1 ___________________________ **Parent/Guardian 2** _________________________
Phone (cell) ___________________________________ Phone (cell) _______________________________
Home ____ Home ____________________________________
Work ____ Work ____________________________________
Emergency Contact – Must be different than parents/guardians listed above
Name:____ Relationship: _____________________________
Cell Phone:_____________________________________ Other Phone: _____________________________
Medical Insurance: ____________________________ Pre-authorization Required? ❒ Yes ❒ No
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

(To be completed by parent/guardian & reviewed by your doctor)

Dietary Restrictions: (Vegetarian, vegan, lactose intolerant, etc.; please describe restrictions):____________

____

____

Allergies (including medicines, foods, bites, stings) ❒ YES* ❒ NO (*If yes, complete below)

Allergy	Reactions	Date of Reaction	Medication

Current Exercise Activity:

Activities	Frequency	Time/Distance	Leisurely	Moderate	Intense
			❒	❒	❒
			❒	❒	❒
			❒	❒	❒

Swimming Ability: ❒ Non Swimmer ❒ Weak Swimmer ❒ Moderate Swimmer ❒ Strong Swimmer

3543 Eighteenth Street, Suite 18 • San Francisco, CA 94110
Phone: 415.864.0780 • Fax: 415.861.3464 • www.girlventures.org

Medications: Is participant currently taking medications? ❒ YES ❒ NO

Please explain all medications (use additional sheets if necessary.)

Medication	Condition	Dosage (amt/frequency)	Side Effects

Is participant currently taking meds for a psychological or behavioral condition? ❒ YES* ❒ NO

**If "YES"– You Must Complete our Psychotropic Med Form, available online or call to request one via mail*

Asthma

Does participant have asthma?	❒ YES*	❒ NO
Has she ever had an asthma attack?	❒ YES*	❒ NO

**If "YES" – You Must Complete our Asthma Evaluation, available online or call to request one via mail.*

Medical History Please check YES/NO for each line: have any of the following been areas of concern?

	YES	NO		YES	NO		YES	NO
eyes	❒	❒	lungs	❒	❒	heart palpitations	❒	❒
contact lenses	❒	❒	asthma	❒	❒	recent broken bone	❒	❒
ears/hearing	❒	❒	diabetes	❒	❒	medical equipment	❒	❒
neck/shoulders	❒	❒	heart murmur	❒	❒	shortness of breath	❒	❒
seizure/epilepsy	❒	❒	back problems	❒	❒	restrictions to strenuous activity	❒	❒
dizziness/fainting	❒	❒	pregnant	❒	❒	recent surgery	❒	❒
knee/ankle	❒	❒				Hospitalization/emergency room visit w/in past year	❒	❒

Explain YES answers here: ______________________________

Any other illnesses/conditions that could affect participation: (include symptoms, treatment, restrictions)

Personal Background – We ask about personal histories to best serve and to ensure the safety of all participants on our courses. Has the applicant had any experiences with the following?

	YES	NO		YES	NO
Eating Disorders	❒	❒	Acrophobia (fear of height)	❒	❒
ADD/ADHD	❒	❒	Cutting and/or Hurting herself	❒	❒
Current bedwetting	❒	❒	Violent/Aggressive Behavior	❒	❒
Substance Abuse	❒	❒	Physical/Sexual Abuse	❒	❒
Depression	❒	❒	Suicidal Ideation	❒	❒
			Other	❒	❒

Explain YES answers here: ______________________________

Counseling/Therapy: Has the applicant been in counseling with a psychiatrist, psychologist, therapist or other counselor within the last 2 years for other than academic reasons? ❒YES* ❒ NO

Reason for counseling: ______________________________

____________________ If applicable, when was counseling terminated? __________

**If YES – You Must Complete our Therapist Information Release, giving GirlVentures permission to contact participant's therapist, thereby ensuring a safe course. Available online or call to request one by mail.*

Juvenile Justice: Has participant been involved in a crime and/or the juvenile justice system? ❒YES ❒NO

If yes, please explain: ______________________________

PART 3 – PHYSICIAN'S SECTION

(To be completed and signed by physician, physician's assistant, or nurse practitioner)

To the examining physician:
Please help us screen for 2-week outdoor expeditions for 6–9th grade girls to enhance program experiences and avoid serious medical events. We rock climb, kayak, backpack, and live outside in tents for 14 days · our programs are physically and mentally strenuous & are designed for adolescent girls. Please screen for clues to potential problems and the possible need for further evaluation. We will be happy to answer any questions you may have about specific program activities. Feel free to call us at: (415) 864-0780 ext 304

- **Review PART 2** (Personal History)
- **Complete PART 3.**

Patient's Name: ________________________________How long have you known the patient?_______

Age	Height	Weight
Blood Pressure (within 6 mos.)	BP /	Date
If systolic/diastolic is over 150/80, please take a 2nd reading. BP #2		
Tetanus Immunization (Required within 10 years)		Date

Exam Check List	Normal	Abnormal	Explain w/relevant dates and current status:
Eyes, ears, nose	☐	☐	
Lymph nodes	☐	☐	
Chest/respiratory	☐	☐	
Cardiovascular	☐	☐	
Abdomen/ GI	☐	☐	
Genitourinary	☐	☐	
Musculoskeletal	☐	☐	
Neurological	☐	☐	
Skin	☐	☐	

Do you feel there is any reason (physical or psychological) the patient could not fully participate in the program activities? (If so, please explain): ____

____

Examining Physician's Information:

Name	Phone
Address	Fax
City/State	Zip

X____ ______________
Physician's Signature **Date**

PART 4 - GUARDIAN CONSENT AND SIGNATURES

Students with medical/psychological issues **can** successfully complete a GirlVentures course, but we must be aware of these conditions. Failure to disclose such information could result in harm to your participant and fellow students. Please let us know about anything that might affect her participation in the course. If your child arrives at the program start with a pre-existing condition or injury that is not indicated on the medical form and she is subsequently forced to leave the course because of that condition, you will be charged an evacuation fee and will not receive a refund of tuition.

Consent is hereby given for this applicant to participate in a GirlVentures program and permission is given for any emergency anesthesia, operation, hospitalization, or other treatment, which might be necessary.

X____ ______________
Parent/Guardian Signature **Date**