# Health History Form

Participant's Name_____ Birth date _____
Address _____ Apt. _____
City_____ State _____ Zip _____
Parent _____
Home _____ Work _____ Cell _____
E-mail _____
Person to contact in an emergency _____
Phone _____
Doctor's Name _____Phone _____
Health Insurance Company_____ ID#_____

**Dear Parent or Guardian;**
**We would like to maximize your son/daughter's experience in the Outdoor Recreation Program. Please take the time to completely fill out the information below. Use additional paper if necessary. All information will help the Adventure Leader to insure that your child has the best experience. Please do not hesitate to contact us with questions or concerns at 768-5349. Don't forget to attach a current copy of your health insurance card to this form.**
**Thank you,**
*The Outdoor Recreation Staff*

**Tell us about the participant's favorite activities:**

_____

**Tell us about the participant's least favorite activities:**

_____

**Has the participant had any of the following (please check):**
*Please provide explanation of any health problems checked, including dates, hospitalization, and treatments*

| | | | | |
|---|---|---|---|---|
| **___Heart Problems** | **___Mumps** | **___Tonsillitis** | **___Nosebleeds** | **___Chicken Pox** |
| **___Appendicitis** | **___Fainting** | **___Measles** | **___Frequent Colds** | **___Asthma** |
| **___German Measles** | **___Headaches** | **___Hay Fever** | **___Rheumatic Fever** | **___Bed Wetting** |
| **___Sinus Problems** | **___Scarlet Fever** | **___Constipation** | **___Ear Infections** | **___Diphtheria** |
| **___Upset Stomach** | **___Food Allergies** | **___Allergic reaction to insects** | **Other: _____** | |

**Remarks:** _____

**Describe any physical limitations:** _____

**Describe any mental limitations:** _____

**Describe any sources of frustrations:** _____
**Any adaptations needed for full participation? (Glasses, hearing aids, walkers, AFO's, wheelchair, simple instructions, other?)** _____

**DD Waiver ___Yes ___No Disability Classification:** _____

**Drug Allergy: _____Serious injuries or illness: _____**

**Medical treatment during the past year: ____ Yes ____ No Date: _____**
**Reason: _____**

**Does the participant take any medication? ____ No ____ Yes *Complete Request for Medication Form**

- **Prescription Drugs must be in original pharmacy containers.**
- **Notify adventure leaders if any medication is brought on the trip.**

**Permission to dispense Tylenol / Ibuprofen: ____ Yes___ No**

## Immunizations

**Please give the year of the last immunization or booster.**

| | | | |
|---|---|---|---|
| **_____Tetanus** | **_____German Measles** | **_____Diphtheria** | **_____Hepatitis A** |
| **_____Polio** | **_____Hepatitis B** | **_____Mumps** | **_____Measles** |

**Please list two adults that can be contacted in an emergency:**

**(1st) _____**
**Name Relationship Phone Number**

**(2nd)_____**
**Name Relationship Phone Number**

**AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR AT AUTHORIZED HOSPITAL IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT**

I (We), the undersigned parent(s) of _____, a minor, do hereby authorize the Adventure Leaders of the Outdoor Recreation Program as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any position or surgeon, licensed hospital whether such diagnosis or treatment is rendered at the office of said physician or at the said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being given in advance of any specific diagnosis, treatment, or hospital care being required but it is given to provide authority and power on the part of aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain effective until _____, unless sooner revoked in writing and delivered to said agent(s).

**Signature of Parent/Guardian _____ Date: _____**
**NOTE: The signing of this Consent to Treatment Authorization is requested for your protection.**