Health Profile & Emergency Information Form

PARTICIPANT INFORMATION

Student Name: _____

Parent Name: _____

Address: _____

Year in School: _____ Birthdate: _____

Age: _____ Height: _____ Weight: _____

Family Doctor's Name: _____ Doctor's Phone: _____

Address: _____

Insurance Company: _____ Insurance Co Phone: _____

Address: _____

Name of Parent/Guardian on Insurance Policy: _____

Policy #: _____ Group #: _____

Medic Alert Number (if applicable): _____

EMERGENCY CONTACT INFORMATION

Please provide at least two contacts

First Contact

Name: _____

Relationship: _____

Address: _____

_____

Day Phone: _____

Evening Phone: _____

Second Contact

Name: _____

Relationship: _____

Address: _____

_____

Day Phone: _____

Evening Phone: _____

1. **Please check if your child has any of the following:**

- ☐ Migraine
- ☐ Diabetes
- ☐ Chronic nose bleeds
- ☐ Color blindness
- ☐ Epilepsy
- ☐ Asthma
- ☐ Travel Sickness
- ☐ Heart Condition
- ☐ Seizures of any kind
- ☐ Dizzy Spells
- ☐ Other (please specify):

_____

_____

2. **Is your child currently taking medication(s)?** Yes _____ No _____

If Yes, please state Ailment(s): _____

Name of medication(s): _____

Dosage and time(s) to be taken: _____

Other treatment: _____

3. **Has your child had any major injuries (breaks or strains) or illness in the last 6 months that may limit full participation in any activities?** Yes _____ No _____

If Yes, please state the injury or illness: _____

4. **Is your child allergic to any of the following?**

	Yes	No	Please Specify
Prescription medication	☐	☐	_____
Food	☐	☐	_____
Insect bites/stings	☐	☐	_____
Other Allergies	☐	☐	_____

What treatments are required? _____

_____

5. **When was your child's last tetanus shot?** (date) _____ / _____ / _____

6. **Please outline any dietary requirements or restrictions:**

_____

_____

7. **Which of the following over-the-counter medications may be given to your child for the following symptoms: (please check)**

    _____ Tylenol (for pain not associated with dehydration)

    _____ Benadryl (for minor allergic reactions)

    _____ Imodium (for diarrhea)

    _____ EpiPen (epinephrine for severe allergic reactions, including compromised breathing)

8. **To the best of your knowledge, has your child been in contact with any contagious or infectious diseases in the last four weeks?** Yes _____ No _____

    If Yes, please give brief details: _____

    _____

9. **Is there any information the staff should know to ensure the physical and emotional state of your child?** Yes _____ No _____

    If Yes, please state or attach the information: _____

    _____

I will inform the school as soon as possible of any changes in the medical or other circumstances between now and the commencement of the trip. In the case of an emergency, I agree to my child receiving any emergency medical treatment as considered necessary by the medical authorities present.

Child Name: _____ **Print Name:** _____

Signed: _____ **Date:** _____ / _____ / _____