



## Health History & Emergency Contact Information Form

Please attach / include the following documents to this completed form:

1. Note of clearance to participate in sports from your child's medical provider.
2. Copy of the front and back of your valid medical insurance card

Full Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Emergency contact #1

Full Name \_\_\_\_\_ relationship: \_\_\_\_\_

Number to call in case of emergency: \_\_\_\_\_  Cell Phone  Home Phone  Work Phone

### Emergency contact #2

Full Name \_\_\_\_\_ relationship: \_\_\_\_\_

Number to call in case of emergency: \_\_\_\_\_  Cell Phone  Home Phone  Work Phone

### Emergency contact #3

Full Name \_\_\_\_\_ relationship: \_\_\_\_\_

Number to call in case of emergency: \_\_\_\_\_  Cell Phone  Home Phone  Work Phone

## Parent/Guardian Authorizations

This health history is correct and complete to the best of my knowledge. The person herein described has permission to engage in all program activities except as noted. I give permission to the college to arrange necessary related transportation for my son or daughter. In the event I cannot be reached in an emergency, I hereby give permission to the clinician selected by the college to secure and administer treatment, including hospitalization, for the person named above. This completed form may be photocopied for trips off campus.

Signature of parent / guardian

Printed Name

Date

\_\_\_\_\_

I also understand and agree to abide by any restrictions placed on my participation in program activities.

Signature of student

Date

## Health History

The following information must be completed by the parent/guardian. The intent of this information is to provide health care personnel and program staff with medical information in order to provide appropriate care. Keep a copy of the completed form for your records. Any changes to this form should be conveyed to a staff member upon participant's arrival. Provide complete information so that the college can be aware of your student's needs.

**MEDICATION ALLERGIES: (List all known)** \_\_\_\_\_

DESCRIBE REACTION AND MANAGEMENT OF THE REACTION: \_\_\_\_\_

**FOOD ALLERGIES: (List all known)** \_\_\_\_\_

DESCRIBE REACTION AND MANAGEMENT OF THE REACTION \_\_\_\_\_

**OTHER ALLERGIES: (Include insect stings, hay fever, asthma, animal dander, etc.)** \_\_\_\_\_

DESCRIBE REACTION AND MANAGEMENT OF THE REACTION \_\_\_\_\_



2020 Adventure Academy

\* This portion of the form will be housed with medical records and transmitted on a need-to-know basis with Adventure Academy Staff

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Medications

Please list ALL medications (including over the counter or non-prescription drugs) taken routinely.

[ ] This person takes NO medication on a routine basis [ ] This person takes medication as follows:

medication #1 dosage \_\_\_\_\_

reason for taking \_\_\_\_\_

medication #1 dosage \_\_\_\_\_

reason for taking \_\_\_\_\_

medication #1 dosage \_\_\_\_\_

reason for taking \_\_\_\_\_

medication #1 dosage \_\_\_\_\_

reason for taking \_\_\_\_\_

medication #1 dosage \_\_\_\_\_

reason for taking \_\_\_\_\_

General Questions (Indicate by circling Y for yes, N for no. Explain "yes" answers below.)

Has/Does participant:

- Y / N 1. Had any recent injury, illness or infections disease? Y / N 16. Ever had back problems?
Y / N 2. Have a chronic or recurring illness/condition? Y / N 17. Ever had problems with joints (e.g. knees, ankles)?
Y / N 3. Ever been hospitalized? Y / N 18. Have an orthodontic appliance being brought to campus?
Y / N 4. Ever had surgery? Y / N 19. Have any skin problems (e.g., itching, rash, acne)?
Y / N 5. Have frequent headaches? Y / N 20. Have diabetes?
Y / N 6. Ever had a head injury? Y / N 21. Have asthma?
Y / N 7. Ever been knocked unconscious? Y / N 22. Had mononucleosis in the past 12 months?
Y / N 8. Wear glasses, contacts or protective eye wear? Y / N 23. Had problems with diarrhea/constipation?
Y / N 9. Ever had frequent ear infections? Y / N 24. Have problems with sleepwalking?
Y / N 10. Ever passed out during or after exercise? Y / N 25. If female, have an abnormal menstrual history?
Y / N 11. Ever been dizzy during or after exercise? Y / N 26. Have a history of bed-wetting?
Y / N 12. Ever had seizures? Y / N 27. Ever had an eating disorder?
Y / N 13. Ever had chest pain during or after exercise? Y / N 28. Ever had emotional difficulties for which professional help was sought?
Y / N 14. Ever had high blood pressure?
Y / N 15. Ever been diagnosed with a heart murmur?

please explain "yes" answers here, noting the number of the questions: \_\_\_\_\_

Name of Student's physician/doctor's office and phone #: \_\_\_\_\_

Date of student's last Tetanus: \_\_\_\_\_

Please send completed forms to:

Email: summer@landmark.edu

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Putney, VT 05346

Fax: 802-387-6868