South Portland Outing Club 2014-15

INSURANCE & HEALTH PROFILE – two pages

Participant's Name _____

Address _____

Home Phone _____ Cell Phone _____

Year in school _____ Age _____ Birth Date _____

Family Doctor's Name _____ Doctor's Phone _____

Address _____

Insurance Company _____ Insurance Phone _____

Policy # _____ Group # _____

Address _____

Name on policy _____

EMERGENCY CONTACT INFORMATION: *In case of emergency, who should we call?*

FIRST CONTACT

Name _____

Relationship _____

Address _____

Day Phone _____

Evening Phone _____

Cell Phone _____

SECOND CONTACT

Name _____

Relationship _____

Address _____

Day Phone _____

Evening Phone _____

Cell Phone _____

- I will inform the school as soon as possible of any changes in the medical or other circumstances between now and the commencement of a trip.

- In the case of an emergency, I agree to (my child) receiving any emergency medical treatment considered necessary by the medical authorities present.

_____

Participant's Printed Name -OR- **Parent/Guardian's Printed Name if participant is under 18 years**

_____

Participant's Signature -OR- **Parent/Guardian's Signature if participant is under 18 years**

Date ____/_____/_____

Details on these forms will remain confidential to the school and volunteers associated with supervising and leading this organization.

Health Profile continued…

1. Please check if participant has any of the following:

Migraine	☐	Epilepsy	☐	Asthma	☐
Diabetes	☐	Travel sickness	☐	Seizures of any type	☐
Chronic nose bleeds	☐	Heart condition	☐	Dizzy spells	☐
Color blindness	☐	Other (please specify) _____			

2. Does participant 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 participant had any major injuries (breaks or strains) or illness in the last six months that may limit full participation in any activities? Yes ____ No_____

If Yes, please state the injury or illness _____

4. Is participant 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 participant'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 participant for the following symptoms: (please check)

____ Tylenol (for pain not associated with dehydration)
____ Benedryl (for minor allergic reactions)
____ Immodium (for diarrhea)
____ Epi Pen (epinephrine for severe allergic reactions, including compromised breathing

8. To the best of your knowledge, has participant 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 safety of participant?

Yes ____ No _____

If yes, please state or attach the information _____