Participant Health History 2019

Name: ____________________ Gender: ___________ Age: ____

Trip: ________________ Birthday: ___/___/____ Weight/Height: ______

Please follow the instructions carefully and complete this form as thoroughly as possible. It should be submitted two weeks before your program.

CONTACT INFORMATION

PARTICIPANT

Name: ____________________________ **E-mail:** ____________________________ **Phone:** ____________________

Home Address: ____

If a minor: **PARENT/GUARDIAN CONTACT (w/ legal custody)**

Name: ____________________________ **E-mail:** ____________________________ **Phone:** ____________________

Home Address: ____

EMERGENCY CONTACT

Name: ____________________________ **E-mail:** ____________________________ **Phone:** ____________________

Home Address: ____

PRIMARY CARE PHYSICIAN

Name: ____________________________ **E-mail:** ____________________________ **Phone:** ____________________

Office Address: ____

ALLERGIES & RESTRICTIONS

ALLERGIES: ☐ **No known allergies** **Allergic to:** ☐ **Food** ☐ **Medicine** ☐ **Environment** ☐ **Other**

Please describe below what the participant is allergic to, and the reaction seem:

Allergen:

Severity/Reaction:

Treatment:

DIET: ☐ **No dietary restrictions** ☐ **Vegetarian:** ☐ **Vegan:** ☐ **Gluten Free:** ☐ **Other (please describe):**

Please describe the restrictions below, and any other dietary preferences or concerns:

MEDICAL INSURANCE

Insurance Company: __________________ **Policy #:** ________________________

Subscriber: ____________________________ **Subscriber Birth Date:** ___/___/____

Please include a scanned copy of your insurance card, and (for minors) immunization record.

Participant Health History

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MEDICATION

If participant will have medication on the trip, please complete the following. Attach sheets as needed.

Medication	Reason	Time Given	Dose Given	How is it given?

Please do not administer the following:

Adult participants may manage their own medication. Minors must have medication administered by staff.

ADDITIONAL INFORMATION

Has the participant…
(check all that apply)

- ☐ Ever been hospitalized?
- ☐ Ever had surgery?
- ☐ Have a recurrent/chronic illness?
- ☐ Have a recent infectious disease?
- ☐ Had a recent injury?
- ☐ Had asthma/wheezing/shortness of breath?
- ☐ Had diabetes?
- ☐ Had seizures?
- ☐ Had headaches?
- ☐ Wear glasses, contacts, or protective eyewear?
- ☐ Had fainting or dizziness?
- ☐ Passed out/had chest pain during exercise?
- ☐ Had mononucleosis ("mono") in the past 12 months?
- ☐ Had problems falling asleep/sleepwalking?
- ☐ Had back/joint problems?
- ☐ Had a history of wetting the bed?
- ☐ Had problems with diarrhea/constipation?
- ☐ Had any skin problems?
- ☐ Traveled outside of the country in the past 9 months?
- ☐ If female, have problems with periods/menstruation?

- ☐ Ever been treated for attention deficit disorder (ADD) or ADHD?
- ☐ Ever been treated for emotional or mental health problems, or an eating disorder?
- ☐ Ever been treated for behavioral problems?
- ☐ Had a significant life event that continues to affect the participant's life?
- ☐ During the past 12 months, seen a professional to address mental/emotional health concerns?

Please provide any context on boxes above checked "yes." Provide a separate sheet if necessary.

Date of most recent physical: ____/____/______ Physician Administering: ______________

This health history is correct and accurately reflects the health status of the participant to whom it pertains. The person described has permission to participate in all provided activities except as noted by me and/or an examining physician. I give permission to the medical provider(s) selected by BOAT to order x-rays, routine tests, and treatment related to the health of myself or my child for both routine health care and in emergency situations. If I cannot be reached in an emergency or am unable to communicate, I give my permission to the physician to hospitalize, secure proper treatment for, and order injection, anesthesia, or surgery for myself or my child. I understand the information on this form will be shared on a "need to know" basis with BOAT staff. I give permission to photocopy this form. In addition, BOAT has permission to obtain a copy of mine or my child's health record from providers who treat myself or my child and these providers may talk with the program's staff about health concerns as necessary for the program.

Name: ___________________ (if signing for a minor) Relationship to participant: ________________

Signature: ________________ Date: ___/___/______