YOUTH MEDICAL FORM

LAST NAME | FIRST NAME | MIDDLE NAME/INITIAL

DOCTOR'S NAME | DOCTOR'S PHONE NUMBER | HEALTH CARD NUMBER

MEDICAL NEEDS & INFORMATION

Attach additional forms if needed

DOES THIS CHILD HAVE LIFE THREATENING ALLERGIES?
☐NO ☐YES

If yes please attach additional Anaphylaxis form

DOES YOUR CHILD HAVE ANY NON-LIFE THREATENING ALLERGIES ☐NO ☐YES
IF YES PLEASE SPECIFY:

DOES THIS CHILD HAVE ASTHMA?
☐NO ☐YES ➔IF SO, HOW SEVERE:
☐MILD ☐MODERATE ☐SEVERE ☐ACTIVITY INDUCED

Please detail medications & treatment plan:

****If your child requires an epi-pen or inhaler please leave them with the instructor and discuss this plan with your child and the instructor****

HEALTH HISTORY

Has your child experienced, currently experiencing, taking medication, or seeking treatment for any of the following:

☐BACK/NECK PAIN OR INJURY
☐BEHAVIORAL ISSUES
☐BLACKOUTS/FAINTING
☐BLEEDING DISORDERS
☐CHEST PAINS
☐CHRONS/COLITIS/IBS
☐CONCUSSIONS
☐DEVELOPMENTAL OR LEARNING DISABILITIES
☐DIABETES
☐EPILEPSY/SEIZURES
☐FETAL ALCOHOL SYNDROME
☐HEADACHES/MIGRAINES
☐HEART/KIDNEY/ORGAN CONDITIONS
☐MOTION SICKNESS
☐NOSEBLEEDS
☐SPRAINS/STRAINS /FRACTURES
☐OTHER, PLEASE EXPLAIN:

****In case of incident or emergency please describe the current status of any conditions/concerns selected above on the back page****

DOES THIS CHILD HAVE A CURRENT TETANUS IMMUNIZATION?: ☐NO ☐YES

DOES THIS CHILD HAVE ANY LIMITATIONS TO PARTICIPATION? (PHYSICAL, EMOTIONAL, SOCIAL OR OTHERWISE THAT WILL AFFECT THEIR ENJOYMENT OF THE PROGRAM): ☐NO ☐YES ➔ PLEASE EXPLAIN:

MAY THE FOLLOWING OVER-THE-COUNTER MEDICATIONS BE ADMINISTERED TO YOUR CHILD IF DEEMED NECESSARY BY WILDERNESS FIRST RESPONDER CERTIFIED INSTRUCTORS?
☐ACETAMINOPHEN (TYLENOL) ☐ANTACIDS ☐ANTIHISTAMINES (BENADRYL) ☐GRAVOL ☐IBUPROFEN (ADVIL) ☐NONE

EMOTIONAL CONSIDERATIONS:

Attach additional information if needed

IN THE PAST YEAR HAVE THERE BEEN ANY CHANGES IN THE HOME OR FAMILY?
☐BIRTH ☐MARRIAGE ☐DIVORCE ☐SEPARATION ☐DEATH ☐OTHER ☐NONE

DOES YOUR CHILD MAKE FRIENDS EASILY WITH... ☐YOUNGER KIDS ☐OLDER KIDS ☐SAME AGE ☐ADULTS

IS YOUR CHILD ... ☐EAGER TO ATTEND ☐NERVOUS OR ANXIOUS TO ATTEND ☐URGED BY PARENTS OR GUARDIAN TO ATTEND

DOES THIS CHILD HAVE ANY OTHER EMOTIONAL NEEDS OR CONSIDERATIONS? ☐NO ☐YES ➔ PLEASE DESCRIBE:

I, _____, do hereby declare that I am the parent or legal guardian of the above participant, and consent that he/she may participate in activities at Hoodoo Adventure Company. I certify that the above information is true and accurate, and agree to advise Hoodoo Adventure Company, in writing, of any change to the medical condition of the person listed above. I understand that unless Hoodoo Adventure Company hears from me otherwise, they will assume all medical information is unchanged from the date of this agreement.

PARENT/GUARDIAN SIGNATURE | PARENT/GUARDIAN NAME | DATE

YOUTH MEDICAL FORM
EXTENDED INFORMATION (FOR OVERNIGHT TRIPS)

LAST NAME | FIRST NAME | MIDDLE NAME/INITIAL

DOCTOR'S NAME | DOCTOR'S PHONE NUMBER | HEALTH CARD NUMBER

DIETARY NEEDS & ADDITIONAL MEDICAL INFORMATION:

DOES THIS CHILD HAVE ANY DIETARY RESTRICTIONS: ☐VEGETARIAN ☐VEGAN ☐LACTOSE INTOLERANT ☐GLUTEN INTOLERANT/CELIAC ☐OTHER ➔ PLEASE SPECIFY:

WILL YOUR CHILD BE UNDERGOING ANY DIETARY OR MEDICAL TREATMENTS WHILE AT CAMP? ☐NO ☐YES ➔PLEASE SPECIFY & EXPLAIN TREATMENT, DOSAGE, ETC.

****Please leave all medications with the instructor on departure day of their overnight expedition****

HEALTH HISTORY:

HAS YOUR CHILD EVER EXPERIENCED, OR ARE THEY CURRENTLY EXPERIENCING, ANY OF THE FOLLOWING WHICH MAY AFFECT THEIR OVERNIGHT EXPERIENCE?

☐ATHLETE'S FOOT
☐BEDWETTING
☐DENTAL BRACES/CAPS/BRIDGES
☐EAR INFECTIONS
☐EATING DISORDERS
☐GLASSES OR CONTACTS
☐HOMESICKNESS
☐MENTAL HEALTH CONCERNS (DEPRESSION/ANXIETY ETC)
☐MENSTRUATION CONCERNS
☐NIGHTMARES/TERRORS
☐SINUS INFECTIONS
☐SKIN CONCERNS OR CONDITIONS
☐SLEEPWALKING
☐URINARY TRACT INFECTION
☐OTHER

PLEASE EXPLAIN:

IS THERE ANY OTHER INFORMATION YOU WOULD LIKE TO DISCLOSE WITH HOODOO ADVENTURES' STAFF?

IMPORTANT DISCLOSURE INFORMATION:

Information collected here is considered to be confidential and will be shared amongst healthcare providers (such as Emergency Health Care Providers, Walk-In Clinics, etc). This information will only be shared with Hoodoo Staff on a strict need-to-know basis to ensure the physical and mental well being of my child.To the best of my knowledge, my child is in good health. I will notify Hoodoo Adventures in writing prior to arrival if there is any change in my child's health, or if he or she is exposed to any communicable disease within 3 weeks prior to the camp. In the case of a medical emergency, I understand that every effort will be made to contact parents or guardians. In the event that I cannot be reached, I hereby give permission to Hoodoo Adventures to facilitate proper care for my child such as hospitalization, securing proper treatment, order injection, anesthesia, or surgery for my child as named above. I agree to reimburse Hoodoo Adventures for any prescriptions or medical expenses incurred for this camper.

I will submit any changes to this health form in writing to Hoodoo Adventures prior to arrival.

PARENT/GUARDIAN SIGNATURE | PARENT/GUARDIAN NAME | DATE

HOODOO ADVENTURES

YOUTH MEDICAL FORM NECESSARY NOTES

LAST NAME | FIRST NAME | MIDDLE NAME/INITIAL

DOCTOR'S NAME | DOCTOR'S PHONE NUMBER | HEALTH CARD NUMBER

HEALTH HISTORY INFORMATION & TREATMENT NOTES:

Please describe any treatment, medication dosage & timing, or additional notes with regards to your child's health history:

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PARENT/GUARDIAN SIGNATURE | PARENT/GUARDIAN NAME | DATE