Health History & Emergency Form

Medical Consent

Attendee under age 18 must have Parent or Legal Guardian's Signature

In accordance with the American Camping Association and the Laws of the State of Tennessee, Doe River Gorge must have a Medical Consent/Health History Form for each attendee which must be completed and signed by the attendee or parent/legal guardian for any person under age 18. Attendees cannot begin the program unless this form is completed and the required signatures are provided. Please be aware that Doe River Gorge does NOT provide medical or hospital insurance coverage.

Attendee Name_____**Dates of Program**_____

By signing my name below, I give my informed consent to the Medical Staff personnel assigned by Doe River Gorge Ministries, Inc. who are certified in a minimum of CPR and First Aid by a nationally recognized provider to provide basic First Aid and comfort measures for this attending adult or minor child including the use of over-the-counter medications. I authorize Doe River Gorge Ministries, Inc. to arrange for or provide any necessary related transportation to the medical facility appropriate for urgent or emergency medical treatment. I hereby give permission to the physician at the receiving facility to have access to this medical information, and to secure and administer any medical treatment deemed necessary, including hospitalization. I assume all responsibility for payment for such treatment. I understand that it is my responsibility to make special arrangements for a person with greater health care needs than the Medical Staff personnel can provide within their individual certifications, licenses, and scopes of practice.

I have accurately and truthfully completed this Health History and Medical Information. I represent that this person is in good health and has my permission to participate in all activities, unless otherwise indicated. I will notify Doe River Gorge of any changes in this person's health after the date of this authorization.

Attendee or Parent/Legal Guardian Printed Name

_____

Signature of Attendee or Parent/Legal Guardian

_____

Date_____

When form is complete and signed by parent or legal guardian please fax 423.725.3719 or mail to PO Box 791, Elizabethton, TN 37644-0791.

Health History & Emergency Form

Attendee Name_____ **Birthday** _____/_____/_____

Program Name or AQ Track# _____ **Date of Program** _____

Address_____ **City**_____ **State**____ **Zip** _____

Email_____ (circle one) **Male / Female** **Age** _____

Height_____ **Weight**_____ **Grade** (for camps, indicate grade in fall) _____

Attendee Type (check one) **____Camper** **____Staff** **____Volunteer**

Father or Male Legal Guardian (at this address) Dr / Mr _____ His Cell Phone ____-____-_____
(Circle One)

Mother or Female Legal Guardian (at this address) Dr / Mrs / Ms _____ Her Cell Phone ____-____-_____
(Circle One)

Emergency Contact (other than above) _____ Relationship to Student _____ Emergency Contact Phone _____-_____-_____

Names of Anyone other than parent/legal guardian authorized to pick up or sign attendee out of camp

_____

REQUIRED Medical Information:

Doe River Gorge REQUIRES this information in order to provide appropriate medical care in the event of injury and/or illness while at camp. Doe River Gorge is committed to protecting confidentiality of this information.

Does this person have medical/hospital insurance? Y / N Insurance Carrier_____

Policy #_____ Insurance Verification Phone Number_____-_____-_____

Name of Responsible Party_____ Relationship to Student_____

Address_____ Phone_____-_____-_____

Family Physician_____ Phone____-____-_____ Family Dentist_____ Phone_____-_____-_____

Medical Conditions: *Check "Yes" or "No" for each statement. Explain "Yes" answers on lines below.*

Allergy History

1) Allergic to medication(s).____ □ Yes □ No
2) Allergic to insect stings.____ □ Yes □ No
3) Allergic to certain foods.____ □ Yes □ No
4) Severely allergic to Poison Ivy, Poison Oak, or Sumac. ____ □ Yes □ No

Health History

1) Asthma/wheezing/shortness of breath.____ □ Yes □ No
2) Back or joint problems.____ □ Yes □ No
3) Behavioral or emotional disorders.____ □ Yes □ No
4) Problems with headaches.____ □ Yes □ No
5) Skin problems.____ □ Yes □ No
6) Recurrent/chronic illnesses.____ □ Yes □ No
7) Had Mononucleosis ("mono") in the past 12 months. ____ □ Yes □ No
8) Problems with diarrhea/constipation.____ □ Yes □ No
9) Had surgery in the past.____ □ Yes □ No
10) Learning disabilities. ____ □ Yes □ No
11) Problems with seizures.____ □ Yes □ No
12) Recently had an infectious disease. ____ □ Yes □ No
13) Physical disabilities.____ □ Yes □ No
14) Has diabetes.____ □ Yes □ No
15) A history of bed wetting.____ □ Yes □ No
16) Traveled outside the USA in the past 9 months.____ □ Yes □ No
17) (If female) Problems with periods/menstruation.____ □ Yes □ No
18) Problems with falling asleep/sleepwalking.____ □ Yes □ No
19) Wears glasses, contacts, or protective eyewear.____ □ Yes □ No
20) Under the care of a physician for a specific condition.____ □ Yes □ No
21) Specific limitations/restrictions.____ □ Yes □ No
22) Has one or more of the following chronic conditions: bleeding/clotting disorders, cardiac problems, epilepsy, nervous disorder.____ □ Yes □ No
23) Has had a recent Tetanus shot. (DPT includes Tetanus.)____ □ Yes □ No
24) Has been hospitalized in the past.____ □ Yes □ No
25) Has recently suffered a serious injury.____ □ Yes □ No
26) Has problems with fainting or dizziness.____ □ Yes □ No

Explain here:

_____

_____