Damariscotta River Association's (DRA) Education Program
Participant Health and History Form 2017

Parents/Guardians Names_____

Participants Name_____ (nickname)_____Birthdate_____

Address_____

E-Mail _____ Home Phone_____ Work Phone(s)_____

Cell Phone(s) _____

On behalf of the participant we hereby give permission for the participant to be photographed or videotaped for educational or promotional purposes during the term of this program. ☐ **Yes** ☐ **No** **(please check one)**

Required Non-parent Emergency Contact 1_____ Phone numbers_____

Required Non-parent Emergency Contact 2_____ Phone numbers_____

Insurance: Is this participant covered by family medical and hospital insurance? Yes ____ No ____

Health/Accident Insurance Provider:_____ Policy Number:_____

Name of Personal Physician:_____ Clinic/Hospital:_____

Physician's Phone Number:_____

A photocopy of both sides of your insurance card must be attached to this form.

Health History The information provided here by the parent/guardian is intended to provide Damariscotta River Association (DRA) staff with the background needed to provide appropriate care as well as a safe and healthy camp experience. Any changes to this information should be provided to staff upon arrival at camp. This information will not be used to exclude a participant from participation unless the participant cannot perform program requirements with or without a reasonable accommodation or is determined to be a direct threat to the health or safety of others.

Allergies

1. Is this participant allergic to any food, medication, or other substance? Yes ____ No ____
2. If yes, please list all allergens and describe your child's reaction to them:
   _____
   _____
3. Has this participant ever had any unusual reaction to an insect bite or bee sting? Yes ____ No ____
4. If yes, please explain:
   _____

Dietary Restrictions – Please check all that apply ☐ Does not eat red meat ☐ Does not eat pork ☐Gluten free ☐ Does not eat eggs ☐ Does not eat poultry ☐ Does not eat seafood ☐ Does not eat dairy products
Other:_____

Immunization Record – Please provide the **date** each immunization was received **(or provide a copy of this person's immunization record from your health care provider)**:

Hepatitis B (Hep B) _____
Diphtheria, tetanus, pertussis (DTaP, Tdap) _____
Pneumococcal conjugate (PCV13) _____
Pneumococcal polysaccharide (PPSV23) _____
Measles, mumps, rubella (MMR) _____
Human papillomavirus (HPV2, HPV4) _____
Rotavirus (RV, RV1, RV5) _____
Haemophilus influenza type b (Hib) _____
Inactivated poliovirus (IPV) _____
Influenza (IIV, LAIV) _____
Varicella (VAR) _____
Hepatitis A (HepA) _____
Meningococcal (Hib-MenCY, MenACWY-D, MenACWY-CRM) _____ Tetanus_____

Please complete reverse side

Medications

1. Does this participant currently take any prescribed medication or treatment (including over-the-counter and homeopathic remedies)? **Yes ____ No ____** Medication List:_____
2. Will this participant need to take any medication during camp hours?)? **Yes ____ No ____**
   If yes, please complete the Medications section of the form (below).
3. Please list ALL medications (including over-the-counter medications and homeopathic remedies) taken routinely. Bring enough medication to last the entire camp session. ALL items should be in their original packaging, bottle, or container that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration. Attached additional pages if necessary.

   1. Medication #1 _____ Dosage _____
   Schedule to administer_____ Reason for taking:_____

   2. Medication #2 _____ Dosage _____
   Schedule to administer_____ Reason for taking:_____

4. Does this participant self-administer any medication, such as an inhaler, or carry an epipen or anakit?
   a. **Yes ____ No____ If yes, provide name of medication_____**
   Instructions:_____
5. If it is found necessary by the DRA, do you consent to this participant being given common, over-the-counter medications such as Benadryl, Caladryl, Tylenol, Advil, Motrin, Pepto Bismol, Maalox, Imodium, Tums, cough medicine. **Yes ____ No ____ Participants weight for administration____**

Disabilities or Physical Restrictions Please describe any disabilities or physical restrictions for this participant of which you want us to be aware, and any reasonable adaptations or accommodations that are requested.

_____

_____

Please describe any conditions such as asthma, convulsions, seizures, diabetes, heart condition or physical handicaps. Please use additional sheets if more space is required.

_____

_____

List any treatment (physical or psychological) either on-going or recently completed so we will have an awareness of recent changes or on-going treatment that may impact this participant. _____

_____

Authorization: This health history is correct as far as we know, and to the best of our knowledge the participant is able to engage in all prescribed activities except as noted in this health history. In the case of a medical emergency where the participant is unconscious or unable to give verbal permission, on behalf of the participant we hereby give permission to proceed with any necessary treatment.

I hereby give permission to the Damariscotta River Association (DRA) staff to administer prescribed or other medications, and seek emergency medical treatment including ordering x-rays or routine tests. I give permission to DRA staff to arrange necessary related transportation for my child. In the event I cannot be reached in an emergency, I hereby give permission for the physician selected by DRA staff to secure and administer treatment, including hospitalization, for my child. This completed form may be photocopied for field trips.

On behalf of the participant, we acknowledge that by participating in the program sponsored by the DRA, the participant may be exposed to certain risks including, but not limited to, adverse weather conditions, physical exertion, uneven terrain, encounters with insects and other animals, etc. which may result in injury.

In consideration of DRA providing the participant with the opportunity to participate in this program, on behalf of myself and the participant we hereby agree to release DRA from claims of personal injury or property caused by the negligence of DRA, its directors, officers, employees, volunteers or agents.

Parent/Guardian Signature_____
Printed Name _____ Date _____