

HEALTH INFORMATION: PLEASE FILL OUT COMPLETELY *DOCTOR SIGNATURE NOT REQUIRED*

Do you have, or have you had, any of the following conditions or symptoms?

Current Medical Conditions		Diseases			
1. Bleeding/Clotting Disorders	Yes No	13. Chicken Pox	Yes No	If Participant Has Allergies:	
2. Asthma	Yes No	14. Measles	Yes No		
3. Diabetes	Yes No	15. Mumps	Yes No	23. Do you carry own	
4. Ear Infections	Yes No	16. Other Diseases	Yes No	Epi-pen?	Yes No
5. Heart Defects/Hypertension	Yes No	Allergies			
6. Psychiatric Treatment	Yes No	17. Hay Fever	Yes No	24. Do you carry own	
7. Seizure Disorder	Yes No	18. Iodine	Yes No	Inhaler?	Yes No
8. Immuno-Compromised	Yes No	19. Poison Oak	Yes No	Date of last Tetanus shot: _____	
9. Sleep Walking	Yes No	20. Penicillin	Yes No		
10. Bedwetting	Yes No	21. Bees/Wasps/Insects	Yes No		
11. Other	Yes No	22. Other	Yes No		
12. Hospitalized in the last 5 yrs?	Yes No				

If you have answered "yes" to any of the above items, please explain below. Provide corresponding number.

Question No.	Explanation

Health Questionnaire: (Attach additional pages if necessary to provide complete information.)

Is the participant taking any medication? Yes No Please list all medications** the participant is taking and the purpose of each.

****Please continue to take all medications as prescribed unless otherwise instructed by your physician.**

Is the participant capable of participating in a 5 mile hike? Yes No Are there any restrictions on the participant's physical activity? Yes No

Please describe _____

Does the participant eat **red meat**? Yes No **Poultry**? Yes No **Fish**? Yes No

Does the participant have any **food allergies**? Please specify _____

Does the participant have any **food restrictions**? Please specify _____

Please provide any additional information that is important for us to know to insure the participant has a quality experience.

Name of Physician _____ Telephone Number _____

Medical Insurance carrier _____

Policy #/I.D.# _____ Subscriber Name _____

Additional information attached: Yes No

AUTHORIZATION FOR TREATMENT: PARENT/GUARDIAN MUST SIGN

I agree the above information is correct to the best of my knowledge, and I authorize any adult chaperone or NatureBridge Staff to consent to any X-ray, examination, anesthetic, diagnosis, treatment, and/or hospital care that may be recommended by a licensed physician and/or dentist. For minor illnesses or injuries, I understand that NatureBridge will attempt to contact me at the earliest practicable opportunity. For major illnesses or injuries, NatureBridge will attempt to contact me before the commencement of any medical treatment, unless my child's condition is such that treatment must be commenced immediately before contact with me can be made. Even if I cannot be reached, this authorization remains in full force and effect.

I authorize NatureBridge staff who have received appropriate training to (1) dispense "over the counter" medication, including aspirin, Tylenol, ibuprofen, Benedryl, Neosporin, Pepto-Bismol, and other similar medications; and (2) administer epinephrine via injection for the emergency treatment of anaphylactic shock that may result from an allergic reaction to insect bites, insect stings, food or plants (such as poison oak). This administration is under the direction of Nature Bridge's medical director.

I agree to assume full financial responsibility for any medical care/treatment my child may receive.

****MUST SIGN**** Signature of Parent/Guardian Date:

Print Name of Participant: _____ **Date:** _____

