

**Damariscotta River Association's (DRA) School for Field Naturalist  
Youth Program Health and History Form 2016**

Parents/Guardians Names \_\_\_\_\_  
Participants Name \_\_\_\_\_ (nickname) \_\_\_\_\_ Birthdate \_\_\_\_\_  
Address \_\_\_\_\_  
E-Mail \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone(s) \_\_\_\_\_  
Cell Phone(s) \_\_\_\_\_

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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) _____	Rotavirus (RV, RV1, RV5) _____
Diphtheria, tetanus, pertussis (DTaP, Tdap) _____	Haemophilus influenza type b (Hib) _____
Pneumococcal conjugate (PCV13) _____	Inactivated poliovirus (IPV) _____
Pneumococcal polysaccharide (PPSV23) _____	Influenza (IIV, LAIV) _____
Measles, mumps, rubella (MMR) _____	Varicella (VAR) _____
Human papillomavirus (HPV2, HPV4) _____	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 \_\_\_\_\_