

## Medical Form

Please print 1 form per participant. When completed, mail to **Earthwork Programs, PO Box 961, Williamsburg, MA 01096** (unless it is one week before the Program—in that case, please bring it with you).

Name of Participant \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Program(s) \_\_\_\_\_ Dates \_\_\_\_\_

~ ~ ~ *To be filled out by Attendee, or by Parent/Guardian if registering for a Children's Program* ~ ~ ~

Parent/Guardian's Name \_\_\_\_\_

Email \_\_\_\_\_

Mailing Address \_\_\_\_\_ Street \_\_\_\_\_

Town, State, Zip \_\_\_\_\_

Phone (Day) \_\_\_\_\_ (Evening) \_\_\_\_\_

Can Earthwork Programs use photographs and/or videos for advertising? \_\_\_\_\_ YES \_\_\_\_\_ NO

### EMERGENCY INFORMATION

Emergency Contact (in case Parent/Guardian or other contact is not reachable during Program hours)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_ Policy/Group # \_\_\_\_\_

### IMMUNIZATIONS

Are immunizations up to date? Give most recent immunization dates:

Measles \_\_\_\_\_ Mumps \_\_\_\_\_ Rubella \_\_\_\_\_ Polio \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Has your child had chicken pox? \_\_\_\_\_ yes \_\_\_\_\_ no

### SPECIAL NEEDS

Has your child been diagnosed with any sort of behavioral or physical disability? If so, please describe and suggest strategies you've found effective in handling the disability (feel free to include additional pages if necessary).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Please fill out both pages of this medical form.)

## MEDICAL INFORMATION

Does your child have any of the following health conditions? Check if yes, and give dates below.

<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Poison Ivy Reaction	<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease/defect
<input type="checkbox"/> Frequent Colds	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cramps	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Insect Stings	<input type="checkbox"/> Psychiatric Treatment	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Bleeding/Clotting	<input type="checkbox"/> Hay Fever Disorders	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Constipation
<input type="checkbox"/> Penicillin Allergy	<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Other Allergies _____	<input type="checkbox"/> Other Health Issues _____

Please describe and list dates for any of the above-listed conditions that you checked: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child need to carry a bee sting kit?  yes  no If so, please be sure s/he brings it each day.

Operations or serious injuries (include dates) \_\_\_\_\_

Recurring illness or medical condition \_\_\_\_\_

Current medications (if we need to oversee your child taking medication, please provide details)

\_\_\_\_\_

This health history is correct to the best of my knowledge, and the person herein described has my permission to engage in all prescribed Program activities except as noted.

**Authorization for treatment:** I hereby give permission to Earthwork Programs staff to carry out standard first aid and CPR, and give permission to medical personnel selected by the director to order x-rays, routine tests, and/or treatment, and to release any records necessary for insurance purposes. I give permission to staff to provide or arrange necessary related transportation for my child or myself. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to secure and administer treatment, including hospitalization, for the person named above. If this application is for Camp, this completed form may be photocopied for use at Camp by camp director.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Participant Consent:** I understand and agree to abide with any restrictions placed upon my or my child's Program activities.

Signature of participant \_\_\_\_\_ Date \_\_\_\_\_