

TREKNORTH MEDICAL HISTORY FORM
EXPERIENTIAL EDUCATION: OAP, SLP, FIELD TRIPS

FORM A

TrekNorth Jr. & Sr. High School
Confidential Medical Record

Part I
General Information

Name: _____ M / F

Street Address: _____

City/State/Zip: _____

Home Phone/Cell Phones: _____

Doctor Name/Phone: _____

Emergency Contact #1: _____

Phone #(s): _____

Relationship: _____

Emergency Contact #1: _____

Phone #(s): _____

Relationship: _____

Insurance: Each participant is required to show proof of insurance. Each participant is required to have a photocopy of the front and back of their personal insurance card stapled to this form.

Insurance company: _____

Policy#: _____

Part II
Medical Information

Allergies (medicines, foods, stings, etc.): describe reaction and medications required

Medications: list condition for which they are used, name of med, frequency and side effects

Part III
Medical History

Please describe current health history. Include dates and diagnosis. Use additional sheets if necessary.

Diabetes: _____

Seizures: _____

Pregnancy: _____

Respiratory Problems: _____

Hospitalization/Emergency Room visit within past year: _____

Head/Neck/Back/Shoulder/Leg/Foot/Arm/Hand problems: _____

Cardiac Problems: _____

Special Diet: _____

Other medical history information: _____

Part IV
Cardiovascular Fitness

Height: _____ Weight: _____

Health concerns regarding physical exertion:

Current exercise activity and level (type, frequency, time and distance):

Please initial and sign:

_____ Consent is hereby given for the student to attend a TrekNorth High School Outdoor Adventure Program, Service Learning Program, or Classroom Field Trip Event and permission is given for any emergency anesthesia, operation, hospitalization, or other treatments that might become necessary.

_____ I understand that all information will remain confidential, except when shared with professional medical personnel. I understand that students with medical/psychological difficulties successfully participate in TrekNorth's programs, and TrekNorth must be aware of these conditions. I understand that failure to disclose such information could result in serious harm to the student and/or the group.

Signature (Parent/Guardian):

_____ Date _____

Signature (Student):

_____ Date _____

Form B
TrekNorth High School
Medication Form

Student Name: _____

Medication and Instructions

| |
|---|
| <p><u>Name of Meds:</u> _____</p> <p>Amount to be administered: _____</p> <p>Schedule for administering medication: _____ _____</p> <p><u>Any additional information:</u> _____ _____</p> |
| <p><u>Name of Meds:</u> _____</p> <p>Amount to be administered: _____</p> <p>Schedule for administering medication: _____ _____</p> <p><u>Any additional information:</u> _____ _____</p> |