CBFS Health Form

Required for all Adults and Minors

Please copy and return completed form to staff as soon as possible

Program / Group Name____ Date of trip_______________________

Participant name ____ Age_____ Male______ Female______

Birth date __________ Race _______ *(for reporting purposes only)* Parent/Guardian ____

Home address ____ City ___________________ State _____ Zip code ___________

Home phone __________________________ Work phone _________________________ Fax _____________________________

Cell phone, or other _________________________ E-mail address ____

—The Chincoteague Bay Field Station does not discriminate against applicants by race, creed, sex, or national origin.—

Medical information: *In case of an emergency, please notify:*

1st priority: Name ______________________________ phone ( )___________________ relationship to student: _____________

Alternate: Name ______________________________ phone ( )___________________ relationship to student: _____________

Health history *(Place an "X" next to all that apply, giving approximate dates or details in blank space provided)*

_____Frequent ear infections ____ Heart defect/heart disease ____ Hay fever ____Diabetes ____ Blood/clotting disorder _____ Convulsions

_____Allergies (non-food, please list type and severity) ____

_____Food (please give type and describe severity) ____

_____Insect stings (please describe severity) ____

_____Recent injuries (please list) ____

____ Other health info we should be aware of ____

Do we have permission to administer: Acetaminophen?______________ Ibuprophen?______________ Benadryl?__________

List all medications brought to MSC: ____

____

Is the student taking any medications? Please list dosage, etc.:____

____

Do you wear contacts? ____ YES _____ NO Do you wear glasses? ____ Yes _____ NO

Swimming ability: _____ Non swimmer _____ Beginner _____ Intermediate _____ Advanced

Surgery or serious injuries (dates):____

Chronic or recurring illness:____

Other diseases or details of above:____

Name of family physician___________________________________ Name of dentist/orthodontist________________________

Do you carry family/hospital insurance? _____ Yes ______ No

Policy name and group number: Carrier __________________________ Group or Policy number ________________________

Restricted activities ____

Important Please notify us if the student is exposed to any communicable disease during the three weeks prior to their program.

If your child needs to be picked up by anyone other than school, are there any pick up restrictions? _______________________

Would you like to be added to our mailing list to receive a program brochure, other announcements, and information about CBFS? ____ Yes _____ No

Parent/Participant Authorization: To the best of my knowledge, this health history is accurate, and the person herein described has permission to engage in all prescribed program activities except as noted by me and/or the examining physician. I hereby give permission to the physician selected by the school, teacher or Field Station staff to order X-Rays, routine tests, and treatment for the health of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the school, teacher or Field Station staff to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I am familiar with the activities in which a participant of the Field Station will engage and I (or my child) am physically capable of participating in such activities. I understand that all physical activity has an inherent risk and that my child is participating at his/her own risk. I understand that the program activities in which the above named individual is participating involves risks, including, but not limited to activities around water, environmental factors, and equipment use. I understand these risks and agree to release the Chincoteague Bay Field Station from any liability for loss of property, personal injury or death. I agree that the Field Station staff will retain this form only for a reasonable time, as not to disclose the medical details of my child or my medical policy information. I grant permission for image and likeness (e.g. photo, name, quotes) of my child to be used in publications by the Field Station. This form is also used for diversity reporting.

Signature ____ Date ____