



# CBFS Health Form

Required for all Adults and Minors

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

School / 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 (Check all that apply, giving approximate dates or details in blank space provided)

\_\_\_\_\_ Frequent ear infections \_\_\_\_\_ Heart defect/heart disease \_\_\_\_\_ Hay fever \_\_\_\_\_ Penicillin \_\_\_\_\_ Allergies \_\_\_\_\_ Convulsions

\_\_\_\_\_ Diabetes \_\_\_\_\_ Other drugs \_\_\_\_\_ Bleeding/clotting disorders

\_\_\_\_\_ Food (please give type and describe severity) \_\_\_\_\_

\_\_\_\_\_ Insect stings (please describe severity) \_\_\_\_\_

\_\_\_\_\_ Recent injuries (please list) \_\_\_\_\_

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? \_\_\_\_\_

Add us to your mailing list so we can receive a program brochure and other announcements and information about MSC.

No, I do not want to be added to your mailing list at this time.

**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 \_\_\_\_\_