



LASTING ADVENTURES, INC. Specialists in Wilderness Adventures for Youth
"Developing Skills, Attitudes and Memories to Last a Lifetime"
 P.O. Box 1078 · Groveland, CA. 95321 · 1-800-513-8651
 www.LastingAdventures.com

Participant Medical Form

Participant's Name: _____ Date of Birth: ___/___/___ Sex: ___ Age: ___

Parent/Guardian: _____ Height: _____ Weight: _____

Street Address: _____

City / State / Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Second Parent / Guardian / Emergency Contact (1): _____

Street Address: _____

City / State / Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

If not available in an emergency, notify:

Name / Relationship: _____ Phone: _____

Additional Phone Numbers: _____

<p>Name of family physician: _____ Phone: _____</p> <p>Name of dentist/orthodontist: _____ Phone: _____</p> <p>Insurance: Each participant is responsible for medical expenses.</p> <p>Insurance Company: _____</p> <p>Policy Number: _____ Group Number: _____</p>
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IMPORTANT – This box must be completed for Participation

<p>This health history is correct to the best of my knowledge. As far as I am aware, my child is physically and emotionally capable of participating and has my permission to engage in all camp activities, unless noted otherwise herein. If I have any questions or doubts regarding my child's capability to participate, I understand that it is my responsibility to consult with the appropriate medical provider(s) to so confirm, prior to my child's participation.</p> <p>I hereby give my permission to Lasting Adventures and its representatives and affiliates (including field staff and outfitters):</p> <ol style="list-style-type: none"> To access and review my child's medical information included on this form. To make all medical information available to medical personnel as requested. To provide medications or medical care to my child if needed. <p>Emergency Authorization: In the event of a medical emergency, I authorize Lasting Adventures to provide emergency first aid treatment and/or refer treatment of my child to other medical practitioners. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my child. I agree to pay all costs associated with any medical care and related transportation for the child and to indemnify and hold Lasting Adventures harmless for any costs incurred.</p> <p>This form may be photocopied for use in the field.</p> <p>Signature of parent or guardian: _____</p> <p>Witness: _____ Date: _____</p>
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<p>GEAR REQUEST</p> <p>____ Backpack ____ Sleeping Bag ____ Sleeping Pad</p>

Participant Name:

Adventure Dates:

Health History:

Please list any and all conditions that may impact your child's participation, including but not limited to: heart conditions, asthma, diabetes, epilepsy or other seizure disorders, and psychiatric conditions. For each condition listed, give approximate dates and explain in the space below as needed.

Is the participant currently under the care of a physician, mental health provider, or other medical provider for the conditions listed? _____

Are there any specific activities to be discouraged or limited by physician advice? _____

If Female: Has the participant menstruated? _____
If not, has she been told about it? _____
Is her menstrual history normal? _____

Has she suffered from severe cramps? _____
What is the best treatment? _____

Participant's swimming ability (please check one): ___ Beginner ___ Intermediate ___ Advanced

ALLERGIES: Please list any allergies including medicines, foods, plants, bites, stings, etc.

Allergy	Reactions	Medication Required
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION: Please list any prescribed medication that is currently taken. Please indicate what will be sent with the Participant.

Medication	Condition	Dosage (amount/frequency)	Side Effects
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please include any additional conditions or concerns we should know about including special dietary requests:
