Cal-Wood Renaissance Adventures Program

PARTICIPANT MEDICAL FORM

School or Group Name ___Renaissance Adventures_____________________________________
Program Dates ___July 10-13, 2007___________________

Dear Parent or Legal Guardian of child who is participating in Cal-Wood's RA Program:

For your child to participate, the Colorado Department of Social Services requires that the following medical form is completed and signed by the appropriate persons. Feel free to attach additional sheets to this form to elaborate on any issues or concerns. Thank you for your cooperation! We look forward to a safe and rewarding time with your child.

PARTICIPANT INFORMATION:
Name____ Age____Sex______Date of Birth___________
Address____
Phone___________________

CONTACT INFORMATION:
Name of Parents or Legal Guardians____
Address (if different from participants)

____
Phone #'s:(day)___________________(eve)_________________(cell)________________
(pager)________________ Place of Employment____
Occupation____
Address____
Phone_____________________

Contact person(s) in case of emergency (different from above)

____
Phone__________________ Relationship_______________________
Address____

Name, address, and phone of individuals authorized to take child from Cal-Wood (other than those listed above)

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MEDICAL INFORMATION (for the participant of Cal-Wood RA Program)
Primary Physician____
Phone_______________________
Address____
Health Insurance Company____
Policy #________________

**Please attach a medical screening conducted by a physician within the past 12 months.

A. Describe and provide dates for any known medical history of which Cal-Wood should be aware of: (i.e.: asthma, diabetes, seizures, heart disease, joint problems, bleeding/clotting disorders, psychiatric treatment, sleep disorders)

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B. Does the participant have any allergies to drug or non-drug items? If yes, please elaborate on history of condition (i.e. insect stings or bites, penicillin, hay fever, iodine, food items)

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C. Will the participant be bringing medication to Cal-Wood? If yes, describe name, purpose and dosage information

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D. Are there any physical activities that you wish the participant to be excluded from? If yes, please describe

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E. Is the participant on a restricted diet? Vegetarian? Vegan? If yes, please describe

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F. Any additional information Cal-Wood should be aware of?

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Acknowledgement and Release
Authorization for Medical Treatment

I assume full responsibility for the information given about my child's health and will be responsible for any decisions made regarding participation in activities of Cal-Wood school programs. I understand the nature of the Cal-Wood RA program and recognize that there are inherent risks in such outdoor activities. I will notify Cal-Wood of any changes in my child's health status should they arise after this.

I give permission to Cal-Wood staff to call a doctor or emergency medical service and for the doctor, hospital, or medical service to provide emergency medical or surgical care for my child should an emergency arise. It is understood that the school staff or Cal-Wood staff will make a conscientious effort to locate the emergency contacts listed on the front of this form before any actions will be taken. If it is not possible to locate the emergency contacts listed, I will accept the decisions made concerning medical treatment.

____
Parent or Legal Guardian Signature Date

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Print Name and Relationship to Participant

Photograph Authorization

I agree that any photographs taken by Cal-Wood staff of the participant shall be the property of Cal-Wood and may be used by Cal-Wood at its discretion for any publicity, marketing, and advertising purposes, and I hereby consent to and authorize such use without restriction.

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Parent or Legal Guardian Signature Date