

Medical Form

Email or return to Erin Hines, erin.hines@gastongov.com. Answers are confidential and will not affect acceptance into program.

PLEASE TYPE OR PRINT

Name of participant: _____

Participant preferred name/nickname: _____

Participant preferred pronouns: __ he/him/his __ she/her/hers __ they/them/theirs

Participant age: _____

Participant grade: _____

Date: _____

Home Address: _____

Parent/Guardian Cell: _____

Parent/Guardian Email Address: _____

Contact in case of an emergency: _____

Relationship: _____

Emergency Contact's Phone #: _____

Health Insurance Company: _____

Policy #: _____

Participant Allergies- Please indicate if you are allergic to any of the following:

Bee stings ___ Yes ___ No ___ Don't know

If yes, how do you react? _____

Wasp stings ___ Yes ___ No ___ Don't know

If yes, how do you react? _____

Food ___ Yes ___ No

If yes, please list foods and reaction: _____

Poison Ivy ___ Yes ___ No ___ Don't know

If yes, how do you react? _____

Other Plants ___ Yes ___ No ___ Don't know

If yes, how do you react? _____

Medications ___ Yes ___ No ___ Don't know

If yes, how do you react? _____

What medications do you carry for allergic reactions?

Participant Accessibility

Are you currently suffering from any illness, injury, physical, medical, or emotional condition, or do you have any physical, mental or emotional disability that could affect your participation? ___ Yes ___ No

If yes, explain: _____

Are there any modifications or accommodations we can consider to make your participation more accessible?

Participant Medical History

Do you or have you had the following conditions?

- Dizziness, loss of consciousness, recurring headaches ___ Yes ___ No
- Chest pain, shortness of breath, heart disease, high/low blood pressure ___ Yes ___ No
- History of diabetes, hypoglycemia ___ Yes ___ No
- Depression, anxiety, nervousness ___ Yes ___ No
- Hernia, fracture, dislocation, sprain, injury ___ Yes ___ No
- Surgeries ___ Yes ___ No

If you checked yes to any of the above, please explain:

Please list all medications you are currently taking and purpose:

I certify that this form is a complete and accurate statement of my health and that I have listed any conditions that may prevent me from fully participating. I understand that I am solely responsible for providing my own health insurance and for all medical expenses related to my participation in Gaston Natural Resource's programs. In the event of a medical emergency, I grant my permission for any medical care which might become necessary. (*If participant is under 18 years old, the undersigned parent or legal guardian authorizes participation by minor, and acknowledges agreement and acceptance to all terms of this agreement.)

Signature