

# PARTICIPANT MEDICAL INFORMATION FORM

To be Completed by a Parent or Guardian of the Trip Participant



PLEASE COMPLETE & RETURN AS SOON AS POSSIBLE TO:

Global Works ♦ 1113 South Allen Street ♦ State College, PA 16801

**Note:** The following medical and contact information may be necessary in the unlikely event of illness or accident. The facts you disclose will be kept confidential and will only be used by the home office and the program staff in the field to respond to an injury or illness. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness.

## PART I: CONTACT INFORMATION

Participant's Name \_\_\_\_\_

Program \_\_\_\_\_ Session# \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:    M / F \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Participant's Social Security# \_\_\_\_\_

Home Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

Person(s) we should contact FIRST in case of an emergency: _____	
Name of Custodial Parent _____	<b>Mother / Father/Guardian</b> <small>circle one</small>
Work Phone # ( _____ ) _____	Cell Phone # ( _____ ) _____
Second Parent _____	<b>Mother / Father /Guardian</b> <small>circle one</small>
Work Phone # ( _____ ) _____	Cell Phone # ( _____ ) _____
<b>**Alternate Emergency Contact Person</b>	
Relationship to Participant _____	
Phone# ( _____ ) _____	or Alt. Phone # ( _____ ) _____
Address _____	
City _____	State _____ Zip Code _____

## PART II: INSURANCE AND PROFESSIONAL INFORMATION

Please indicate your hospitalization information for emergency use.

Is the participant covered by family medical/hospital insurance?

- YES  
 NO

If so, please indicate the following information:

Insurance carrier or plan name \_\_\_\_\_

Policy # \_\_\_\_\_

Group Policy # \_\_\_\_\_

Address of Carrier \_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian SS# \_\_\_\_\_

Name of family physician \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Name of family dentist \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

## PART III: PARENTAL CONSENT

**\*Important- this box must be complete for attendance.**

### **PARENT/GUARDIAN AUTHORIZATION:**

This health history is correct and complete as far as I know. The participant herein described has permission to engage in all program activities except as noted.

I hereby give permission to the camp to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

It is understood that in case of emergency, Global Works will make every reasonable attempt to immediately contact this participant's parent(s) or guardian(s). In the event I cannot be reached in an emergency, I hereby give permission to the licensed physician selected by Global Works to secure and administer treatment, including hospitalization, injections, anesthesia or surgery, for my child. This completed form may be photocopied for use of staff in the field.

Parent/Guardian Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Date \_\_\_\_\_

## PART IV: PARTICIPANT MEDICAL HISTORY

Note: While Global Works programs are exciting and rewarding experiences, they can also be physically and emotionally demanding. We ask that you provide a candid evaluation of your son/daughter's health so that we are able to explore the availability of appropriate medical services abroad and provide our staff with the background information to prepare and provide appropriate care for your son/daughter.

1A. Is your son/daughter currently taking any medications on a regular basis?

NO

YES If so, please list ALL medications (including over-the-counter or nonprescription drugs) your child has taken routinely in the past 3 months. (Please attach any additional information)

Medication	Taken For (Condition/Symptom)	Dosage (Size/Frequency)	Date Started	Current Side Effects (if any)

1B. If your son/daughter is currently taking routine medications, do you plan to have your son/daughter continue to take these medications during the program?

NO

YES

If not, please explain:

1C. If your son/daughter is planning on taking routine medications during the program, who will be responsible for handling and administering the medications:

My child will be responsible for administering his/her own medication(s) &/or vitamins

I prefer the Global Works staff to hold onto my son/daughter's medications and dispense them as prescribed.

2. Does your son/daughter have any known allergies (including medication allergies, food allergies, or other)?

NO

YES If so, please list

Type	Describe reaction and appropriate management of reaction

3. Has your son/daughter ever been diagnosed with any mental health conditions?

- NO
- YES If so, please describe:

4. Does your son/daughter have any dietary restrictions we should know about?

Please check any that apply.

- Does not eat red meat
- Does not eat poultry
- Does not eat pork
- Does not eat seafood
- Does not eat eggs
- Does not eat dairy products
- Other (describe):

5. How would you characterize your son/daughter's swimming ability?

- Non-swimmer
- Cannot swim more than 100 yards
- Moderate swimmer
- Strong swimmer

6. Has your son/daughter ever had any history of the following?

(Please check corresponding circle if there is a history.)

- |   |   |   |
|---|---|---|
| <input type="radio"/> Allergies                   | <input type="radio"/> Neck Problem              | <input type="radio"/> Heart Problems  |
| <input type="radio"/> Asthma                      | <input type="radio"/> Shoulder Problem          | <input type="radio"/> Hepatitis   |
| <input type="radio"/> Frequent headaches          | <input type="radio"/> Knee Problem              | <input type="radio"/> Phobias (claustrophobia, etc.)                                |
| <input type="radio"/> Ear infections              | <input type="radio"/> Foot Problems             | <input type="radio"/> Eating Disorders  |
| <input type="radio"/> Cramps                      | <input type="radio"/> Chronic Pain              | <input type="radio"/> Anorexia Nervosa  |
| <input type="radio"/> Diarrhea/constipation       | <input type="radio"/> Diabetes                  | <input type="radio"/> Bulimia   |
| <input type="radio"/> Epilepsy                    | <input type="radio"/> Dizziness                 | <input type="radio"/> Emotional difficulties for which professional help was sought |
| <input type="radio"/> Recent injuries of any kind | <input type="radio"/> Infectious Disease        | <input type="radio"/> Wears glasses, contacts, or protective eye wear               |
| <input type="radio"/> Surgery                     | <input type="radio"/> Fainting                  |   |
| <input type="radio"/> Mononucleosis               | <input type="radio"/> Recurrent Dental Problems |   |
| <input type="radio"/> High Blood Pressure         | <input type="radio"/> Lymes Disease             |   |
| <input type="radio"/> Pneumonia                   | <input type="radio"/> Mental Illness            |   |
| <input type="radio"/> Back Problems               | <input type="radio"/> Gastrointestinal Problems |   |

Please explain any checked item(s) in the space below or on a separate piece of paper if necessary.