

Health History & Emergency Form

Medical Consent

Attendee under age 18 must have Parent or Legal Guardian's Signature



In accordance with the American Camping Association and the Laws of the State of Tennessee, Doe River Gorge must have a Medical Consent/Health History Form for each attendee which must be completed and signed by the attendee or parent/legal guardian for any person under age 18. Attendees cannot begin the program unless this form is completed and the required signatures are provided. Please be aware that Doe River Gorge does NOT provide medical or hospital insurance coverage.

Attendee Name _____ Dates of Program _____

By signing my name below, I give my informed consent to the Medical Staff personnel assigned by Doe River Gorge Ministries, Inc. who are certified in a minimum of CPR and First Aid by a nationally recognized provider to provide basic First Aid and comfort measures for this attending adult or minor child including the use of over-the-counter medications. I authorize Doe River Gorge Ministries, Inc. to arrange for or provide any necessary related transportation to the medical facility appropriate for urgent or emergency medical treatment. I hereby give permission to the physician at the receiving facility to have access to this medical information, and to secure and administer any medical treatment deemed necessary, including hospitalization. I assume all responsibility for payment for such treatment. I understand that it is my responsibility to make special arrangements for a person with greater health care needs than the Medical Staff personnel can provide within their individual certifications, licenses, and scopes of practice.

I have accurately and truthfully completed this Health History and Medical Information. I represent that this person is in good health and has my permission to participate in all activities, unless otherwise indicated. I will notify Doe River Gorge of any changes in this person's health after the date of this authorization.

Attendee or Parent/Legal Guardian Printed Name

Signature of Attendee or Parent/Legal Guardian

Date _____

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Attendee Name _____ Birthday ____/____/____

Program Name or AQ Track# _____ Date of Program _____

Address _____ City _____ State _____ Zip _____

Email _____ (circle one) Male / Female Age _____

Height _____ Weight _____ Grade (for camps, indicate grade in fall) _____

Attendee Type (check one) _____ Camper _____ Staff _____ Volunteer _____

Father or Male Legal Guardian (at this address) Dr / Mr _____ His Cell Phone _____ - _____ - _____
(Circle One)

Mother or Female Legal Guardian (at this address) Dr / Mrs / Ms _____ Her Cell Phone _____ - _____ - _____
(Circle One)

Emergency Contact (other than above) _____ Relationship to Student _____ Emergency Contact Phone _____ - _____ - _____

Names of Anyone other than parent/legal guardian authorized to pick up or sign attendee out of camp _____

REQUIRED Medical Information:

Doe River Gorge **REQUIRES** this information in order to provide appropriate medical care in the event of injury and/or illness while at camp. Doe River Gorge is committed to protecting confidentiality of this information.

Does this person have medical/hospital insurance? Y / N Insurance Carrier _____

Policy # _____ Insurance Verification Phone Number _____ - _____ - _____

Name of Responsible Party _____ Relationship to Student _____

Address _____ Phone _____ - _____ - _____

Family Physician _____ Phone _____ - _____ - _____ Family Dentist _____ Phone _____ - _____ - _____

Medical Conditions: Check "Yes" or "No" for each statement. Explain "Yes" answers on lines below.

Allergy History

- 1) Allergic to medication(s). _____ Yes No
- 2) Allergic to insect stings. _____ Yes No
- 3) Allergic to certain foods. _____ Yes No
- 4) Severely allergic to Poison Ivy, Poison Oak, or Sumac. _____ Yes No

Health History

- 1) Asthma/wheezing/shortness of breath. _____ Yes No
- 2) Back or joint problems. _____ Yes No
- 3) Behavioral or emotional disorders. _____ Yes No
- 4) Problems with headaches. _____ Yes No
- 5) Skin problems. _____ Yes No
- 6) Recurrent/chronic illnesses. _____ Yes No
- 7) Had Mononucleosis ("mono") in the past 12 months. _____ Yes No
- 8) Problems with diarrhea/constipation. _____ Yes No
- 9) Had surgery in the past. _____ Yes No
- 10) Learning disabilities. _____ Yes No
- 11) Problems with seizures. _____ Yes No

- 12) Recently had an infectious disease. _____ Yes No
- 13) Physical disabilities. _____ Yes No
- 14) Has diabetes. _____ Yes No
- 15) A history of bed wetting. _____ Yes No
- 16) Traveled outside the USA in the past 9 months. _____ Yes No
- 17) (If female) Problems with periods/menstruation. _____ Yes No
- 18) Problems with falling asleep/sleepwalking. _____ Yes No
- 19) Wears glasses, contacts, or protective eyewear. _____ Yes No
- 20) Under the care of a physician for a specific condition. _____ Yes No
- 21) Specific limitations/restrictions. _____ Yes No
- 22) Has one or more of the following chronic conditions: bleeding/clotting disorders, cardiac problems, epilepsy, nervous disorder. _____ Yes No
- 23) Has had a recent Tetanus shot. (DPT includes Tetanus.) _____ Yes No
- 24) Has been hospitalized in the past. _____ Yes No
- 25) Has recently suffered a serious injury. _____ Yes No
- 26) Has problems with fainting or dizziness. _____ Yes No

Explain here:
