CAMP SEA LAB HEALTH FORM

Please fill out both pages clearly and completely.
****DOCTOR SIGNATURE NOT REQUIRED****

Office only: Information on this form is current.
Initials ______ Date: ____/____/____

SCHOOL NAME:___________________________

SECTION 1: PARTICIPANT INFORMATION

Participant's Name (please print)	Age	Birth date ___/___/____	Gender: ☐ Female ☐ Male ☐ Trans or non-conforming

Ethnicity of Participant: ☐ African-American ☐ Asian ☐ Caucasian ☐ Mexican/Latino ☐ Native American ☐ Pacific Islander ☐ Multi-ethnic ☐ Other ________________________ ☐ Decline to state

Names of custodial parent/guardian(s)	Email
Address (include city and zip)	Primary Phone: (circle one) home, cell, work ( ) Secondary Phone: home, cell, work ( )

☐ Yes ☐ No Add my name/email to Camp SEA Lab's e-newsletter list for notification regarding programs and events.

SECTION 2: EMERGENCY & MEDICAL CONTACT INFORMATION

Emergency contact name (1)	Relation	Primary: home, cell, work ( )	Secondary: home, cell, work ( )
Emergency contact name (2)	Relation	Primary: home, cell, work ( )	Secondary: home, cell, work ( )

Name of physician	Phone ( )	Date of last physical examination: _____/____/____
Is the Participant covered by medical insurance? ☐ Yes ☐ No	Insurance provider	Policy #: Phone #: ( )

SECTION 3: DIETARY / ALLERGY INFORMATION

Please fill out each section. Use DNA if "does not apply".

Dietary restrictions: ☐ Vegetarian ☐ Vegan ☐ Lactose intolerant ☐ Gluten intolerant ☐ Other __________________

Please list the specific **food, medication,** and/or **environmental factor** (insect/plant/latex) that causes an **allergic reaction**. (If more than 2 items, please provide additional information on a separate sheet.)

Name of item	Item #1:	Item #2:
Cause (check all that apply)	☐ ingestion ☐ touch ☐ airborne	☐ ingestion ☐ touch ☐ airborne
Can Participant eat food that is made in a facility with the allergy item?	☐ yes ☐ no ☐ unsure	☐ yes ☐ no ☐ unsure
Reaction (check one)	☐ fatal ☐ severe ☐ mild	☐ fatal ☐ severe ☐ mild
Describe most recent reaction		
Treatment (check all that apply) Participant must posses item at all times.	☐ Epi-pen ☐ antihistamine ☐ other __________________	☐ Epi-pen ☐ antihistamine ☐ other __________________
Treatment description		

Participant Name: ______________________

SECTION 4: HEALTH HISTORY

Please fill out each section. Use DNA if "does not apply".

Has/does the Participant:	**Yes**	**No**		**Yes**	**No**
Ever have bleeding / clotting disorders?	☐	☐	Have heart defects / hypertension?	☐	☐
Ever had back / joint problems?	☐	☐	Have any physical impairment?	☐	☐
Ever had seasickness?	☐	☐	Have asthma?	☐	☐
Ever have chronic ear infections?	☐	☐	Have hay fever / seasonal allergies?	☐	☐
Ever had psychiatric treatment?	☐	☐	Have seizure disorder?	☐	☐
Have current bed wetting condition?	☐	☐	Have diabetes?	☐	☐
Have current sleep walking condition?	☐	☐	Wear contact lenses or glasses?	☐	☐

Please explain any **"Yes"** items above:

Does the Participant carry: An Inhaler? ☐ Yes ☐ No An Epi-pen? ☐ Yes ☐ No

Immunizations required for school are up to date: ☐ Yes ☐ No with doctor approved medical exemption.

Date of last tetanus shot or booster (TdaP, DTaP, DTP): ____/____/____ ☐ I don't know.

Date of TB (tuberculosis) test: ____/____/____ Results: ☐ Negative ☐ Positive ☐ I don't know.

Please note any health problems the Participant may have experienced or been exposed to in the month prior to program:

Explain any activity restrictions or special needs of the Participant that would be helpful for us to know about:

SECTION 5: AUTHORIZED CONSENT

Note: Statements in this section cannot be altered, edited, or crossed out in any way.

A. PHOTOGRAPH/INTERVIEW CONSENT:

I agree that any photographs/videos taken by any Camp SEA Lab personnel shall be the property of Camp SEA Lab, and may be used by Camp SEA Lab at its discretion for any publicity, marketing, social media and/or advertising purposes, and I hereby consent to and authorize such use without restriction or compensation. I also give permission for Participant to be interviewed about Camp SEA Lab by the news media.

☐ I disagree Initials: _______

B. EMERGENCY MEDICAL CONSENT:

The Participant's medical conditions and information stated on this application is complete and correct. I give permission to the Camp SEA Lab staff to (1) provide appropriate first aid for minor injuries; and (2) seek further treatment from local physicians or hospitals if the medical condition warrants. *In the event I cannot be reached in an emergency*, I also give permission to the treating physician to examine, diagnose, and treat or secure proper treatment for the Participant and hospitalize, and to order injection and/or anesthesia and/or surgery for the Participant, as the physician shall determine proper and necessary under the circumstances. I agree to assume full financial responsibility for the costs of any evacuation and/or medical treatment that the Participant may receive. A photocopy of this consent shall be as valid and may be accepted as the original.

I certify that I have completed all sections of this Health Form and accept full responsibility for any errors or omissions. The Participant has permission to take part in all program activities except as noted above. I understand the information on this form will be shared on a "need to know" basis with Camp SEA Lab staff.

I fully understand that the Participant is to abide by all rules governing personal conduct during all activities. Any violation of these rules may result in the Participant being sent home at the expense of his/her parent/guardian. I understand that no refunds will be given for Participants sent home due to disciplinary procedures or illness and that it is my responsibility to pick up a Participant sent home for such a reason.

X ____

Signature of Parent / Guardian of Participant (under 18) or Participant (over 18) Date

Name of Parent / Guardian (please print) ____

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