TeamWorks Medical Form

Participant Name ______________________________ **Date** ____________________

Instructions:
All the questions on this form are important. The answers are needed in order to assess your level of participation in a field trip. Please answer every question in every section and return the form as soon as possible, in order to allow time for any needed follow-up. Incomplete forms will slow down the screening process, and may prevent you from being able to participate in your field trip.

PART I General Information

APPLICANT
Legal Name ______________________________ Preferred Name (if different) ______________________________
Gender Identity: ______________________________ Sex Assigned at Birth ______________________________
Daytime Telephone # (_____)______________ Evening Telephone # (_____)______________
Age _______ DOB ____/____/____ FAX # (_____)______________
Address ______________________________ Apt. ____ email ______________________
City/State/Zip ______________________________ Do you speak/understand English? Yes ☐ No ☐

PARENT/GUARDIAN
Name ______________________________
Home Telephone # (_____)______________
Work Telephone # (_____)______________
Preferred language (if not English)______________________
FAX # (_____)__________ email ______________________

EMERGENCY CONTACT (other than parent/guardian)
Name/Relationship ______________________________
Daytime Telephone # (_____)______________
Evening Telephone # (_____)______________
Cell Phone # (_____)__________ email ______________________
Preferred language (if not English)______________________

FAMILY PHYSICIAN
Name ______________________________ Telephone # (_____)______________ FAX # (____)______________

INSURANCE INFORMATION (We do not require insurance, but it is helpful if you do have it)

Provider______________________________

Policy Number__________________________

PART II Medical Information

A. Allergies (Including allergies to medicines, foods, insect bites/stings)

NONE ☐ or…

Allergy	Reaction	Medication Required (if any)

B. Medical conditions (Other medical issues/illnesses/symptoms/ requirements/prosthetic device(s)

NONE ☐ or…

Condition	Symptoms and treatment	Medication Required (if any)

CONFIDENTIAL MEDICAL RECORD© Wilderness Medical Associates, Inc. 2001

C. Current Medications (Including psychiatric medication, over-the-counter medication, inhalers)

NONE ☐ or…

Medication	Taken For: (Symptom/Condition)	Dosage	Date Started	Current Side Effects

TEENS, Inc. recommends that all participants have a current tetanus immunization (within 10 years).

PART III Health Profile

#	Please √ one–If yes, describe below	Y	N	#	Please √ one–If yes, describe below	Y	N
1	Seizure within the past 1 year			6	Use of Tobacco/Smoker		
2	Hospitalization/Emergency Room/Urgent Care visit within the past 1 year			7	**Current** Neck/Back/Shoulder/Knee/Ankle/or other joint problem		
3	Asthma (If yes, please bring inhaler)			8	Currently Pregnant		
4	Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, or exertional dizziness or faint spells			9	Bedwetting		
				10	**Diagnosed** Learning Disability and/or ADD/ADHD		
5	Other cardiac conditions, e.g., heart murmur or other rhythm abnormality			11	Other medical issues/illnesses/symptoms/ requirements/prosthetic device(s)		
#	Describe						
#	Describe						

B. Food allergies and preferences (this helps us design our menus)

Please list all the foods that you avoid in your diet and state whether this is a personal preference/religious reason or a diagnosed allergy.

Food or ingredient	Diagnosed Allergy, personal preference, or religious reason?	Common Side Effects	How long since you have eaten this?

C. Current Exercise Activity (Needed as important assessment tool)

Please list the activities you do on a daily or weekly basis which show your current fitness level. Be sure to include activities such as walking a pet, playing basketball, skateboarding, skiing, etc.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

D. Swimming Ability

	Yes	No
Are you able to comfortably swim?	☐	☐

E. Personal History

#	**Based upon past two years**	Yes	No
1	Have you been in counseling with a psychiatrist, psychologist, social worker, or other therapist within the past 2 years?	☐	☐
2	Are you currently in counseling or treatment with a therapist, psychiatrist, psychologist, or prescribing physician?	☐	☐
3	If you answered yes to numbers 1 or 2 above please arrange for a release of information with your therapist and/or prescribing physician so we may contact them for further information, if needed as part of this screening process. **Have you done so?**	☐	☐
4	Please check the appropriate responses that indicate the reason(s) for counseling: ☐ **Academic/Career** ☐ **Divorce** ☐ **Family Issues** ☐ **Maintenance of Medication** ☐ **Substance Abuse** ☐ **Depression** ☐ **Eating Disorder** ☐ **Suicide** ☐ **Other**________________________		
5	Name of current (or most recent) therapist ____ Telephone # (______)________________ FAX # (______)________________ email ______________________________		
6	Name of prescribing physician ____ Telephone # (______)________________ FAX # (______)________________ email ______________________________		

PART IV Signature Required

Consent is hereby given for the applicant to attend the field trip and permission is given for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary.
All information will remain confidential. You should know that over the years, many students with a variety of medical/psychological challenges have successfully participated in our field trips, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow participants.

______________________________ ______________
Parent's/Guardian's Signature (if applicant is under legal age) **Date**

______________________________ ______________
Applicant's Signature **Date**

PART V Consent for Emergency Medical Treatment

I understand that there is a possibility of injury or illness due to participation in a Wilderness or Adventure Based Course, and I authorize TEENS, Inc. staff, representatives, contractors or other medical personnel to obtain or provide medical care for me/my child (including administering over the counter drugs as necessary), to transport me/my child to a medical facility and to provide treatment they consider necessary for participant's health, and will pay all associated costs. I agree to the release (to or by TEENS, Inc.) of any medical records necessary for treatment, referral, billing or insurance purposes.

______________________________ ______________
Parent's/Guardian's Signature (if applicant is under legal age) **Date**

______________________________ ______________
Applicant's Signature **Date**