Kent Mountain Adventure Center, Inc.
P.O. Box 835
Estes Park, CO 80517
(970) 586-5990

Participant Medical Form

To be filled out by parent/legal guardian: Please note: **Physician signature is required on page 2**
COMPLETED FORM IS REQUIRED

Participant Name: _____ Age: ____ Date of birth: _____/_____/_____

Address/P.O. Box: _____

City: _____ State: _____ ZIP: _____

Name of Course: _____

M _____ F _____ Height: _____ Weight: _____ Last physical exam: _____/_____/____

Emergency Contact Name: Parent/Guardian: _____

Day phone: (_____)_____ Night phone: (_____)_____

If parents/guardian cannot be contacted, please contact (list two individuals):

1. Name: _____ **2.** Name: _____

Relationship to participant: _____ Relationship to participant: _____

Home phone: (_____) _____ Home phone: (_____) _____

Business phone: (_____) _____ Business phone: (_____) _____

HEALTH HISTORY

List any chemical or drug allergies (penicillin, sulpha, iodine, etc.): _____

_____
___

List any allergies: food (nuts, fish, peanut butter, dairy, etc.), insects (bee stings, etc.), hayfever (pollen, mold, etc.):

Has participant ever been stung by a bee/wasp: Yes ❑ No ❑

Does the participant have a history of any of the following: Please check all that apply:
❑Asthma ❑respiratory disorder ❑fainting ❑dizziness ❑diabetes ❑hypertension
❑Seizure disorder ❑headaches ❑eating disorder ❑sleep walking ❑bed wetting
❑Depression ❑homesickness ❑heart disease/defect ❑nose bleeds

Does the participant have any other pre-existing medical conditions? Please list:_____
_____
____

Special diet?:
_____

Past history of injuries (include dates):
_____

_____
___

I give permission to Kent Mountain Adventure Center to give the following if deemed necessary to relieve minor pain and discomfort:
Parent/legal guardian signature:_____

Tylenol	Yes ❑ No ❑	Ibuprofen	Yes ❑ No ❑
Imodium for diarrhea	Yes ❑ No ❑	ExLax for constipation	Yes ❑ No ❑
Decongestant	Yes ❑ No ❑	Antihistamine(Benadryl)	Yes ❑ No ❑
Antacid for indigestion	Yes ❑ No ❑	Throat lozenges	Yes ❑ No ❑
Sunblock or sunscreen	yes ❑ No ❑	Hydrocortisone Cream	yes ❑ No ❑
Claritin(loratadine)	yes ❑ No ❑		

Participant's Doctor: _____ Phone: (_____) _____

Doctor's address: _____

I have prescribed the following medications to be administered. I have examined the participant named on this form and found him/her to be in satisfactory physical condition and capable of active participation in an outdoor adventure based program:
Physiciansignature:_____

Name of med.: _____ Name of med.: _____

Dosage: _____ Dosage: _____

Times given: _____ Times given: _____

Date medication started: _____ Date medication started: _____

Reason for medication: _____ Reason for medication: _____

Name of med.: _____ Name of med.: _____

Dosage: _____ Dosage: _____

Times given: _____ Times given: _____

Date medication started: _____ Date medication started: _____

Reason for medication: _____ Reason for medication: _____

Self-Carry medication release for Sun block, Rescue inhalers, Epi-pens and insulin pumps

I request that the above named participant be permitted to carry one or all of the following:
Please check all that apply: (must be prescribed above per physician orders):
❑Sun block ❑Epi-pen ❑Albuterol Inhaler ❑Insulin Pump Pens

❑Other_____

The above noted "self-carry" items/medications are permitted for the indicated participant at all times. He/she has been instructed by the physician and parents and acknowledges the proper understanding of the purpose, frequency, and appropriate method of use of these items.
Parent/legal guardian signature:_____

Additional comments (Please describe on page 4):

IMMUNIZATION RECORD

Attach Colorado Certificate of Immunization or complete the following:

Vaccine		Date of Vaccination
Hep B	Hepatitis B	
DTaP/Tdap	Diphtheria, Tetanus, Pertussis	
DT/Td	Tetanus, Diphtheria	
Hib	Haemophilus influenza type b	
IPV/OPV	Polio	
PCV7	Pneumococcal Conjugate	
MMR	Measles, Mumps, Rubella	
Varicella	Chickenpox	
Vaccines below this line are recommended.		
HPV	Human Papillomavirus	
Rota	Rotavirus	
MCV4/MPSV4	Meningococcal	
Hep A	Hepatitis	

TIV/LAIV	Influenza	
Other		

In case of an emergency, every effort will be made to contact me. In the event I cannot be reached, I hereby give my permission to the physician selected to hospitalize and secure proper treatment (including emergency care) for my child.

Signature of parent/legal guardian: _____ Date: _____

Signature of participant: _____ Date: _____

Medical Health Insurance: Company: _____

Address: _____

Policy #: _____ Group #: _____ Phone: (_____)_____

PLEASE NOTE THE FOLLOWING: ALL PARTICIPANTS ARE REQUIRED TO HAVE A PHYSICAL EXAM BY A PHYSICIAN OR NURSE PRACTITIONER WITHIN ONE YEAR PRIOR TO PARTICIPATION.

If there are <u>any</u> changes in the participant's medical status between now and the course departure, please contact KMAC with the new information as soon as possible (970) 586-5990.

Kent Mountain Adventure Center is licensed by the Colorado Department of Human Services to conduct "trip" camps for children. In accordance with this license, KMAC is required by the Division of Child Care to report suspected child abuse. Any person who suspects child abuse should contact:

Larimer County Department of Human Services
Phone: (970) 498-6300

Any person or entity that wishes to file a complaint against Kent Mountain Adventure Center for suspected licensing violations should contact the Division of Child Care at the address and phone number below.

Colorado Department of Human Services
Division of Child Care
1575 Sherman Street, First Floor
Denver, CO 80203-1714
Phone: (303) 866-3755