Northern Lakes Canoe Base
Health History and Medical Exam Form

Please bring completed form with you to the Canoe Base!

Health History: The more complete information you provide, the better we are able to work with canoe trip participants to ensure they receive the care they need. **Medical Examination:** We require a medical examination by a licensed physician, nurse practitioner, physician's assistant or registered nurse within the preceding 24 months.

Please type or write clearly and legibly.

Name of Participant: (First, Middle Initial, Last)	**Date of Birth:** (XX/XX/XXXX)		
Street Address:	**City:**	**St:**	**Zip:**
Parent or Guardian (N/A if adult participant):	**Phone:**	**Alternate Phone:**	
Parent or Guardian (N/A if adult participant):	**Phone:**	**Alternate Phone:**	

Emergency Contact Information (other than parents listed above):

Emergency Contact:	**Relationship:**
Phone (include alternate) number(s):	**Adult participants – list alternate emergency contact/phone:**

Health Insurance Information (Family insurance is primary insurance in case of accident or illness, Girl Scout insurance is secondary.)

Policy Holder's Name:	**Policy Number:**
Insurance Company Name:	**Group Number:**
Insurance Company Address:	**Insurance Company Phone:**

Check all that apply and explain in detail checked answers:

☐	Diabetes	☐	Sleep disturbances
☐	Heart Defects/Disease	☐	Fainting
☐	Asthma	☐	Bed wetting
☐	Ear Infections	☐	Constipation
☐	Musculoskeletal Disorders	☐	Chicken Pox
☐	Convulsions/Epilepsy/Seizures	☐	Measles
☐	Sinusitis (Sinus Infections)	☐	German Measles
☐	Physical Restrictions	☐	Mumps
☐	Kidney/bladder illness	☐	Rheumatic Fever
☐	Mental/psychological disorder	☐	Tuberculosis
☐	Hypertension	☐	Kidney Disease
☐	Arthritis	☐	Eating Disorders (Anorexia, Bulimia, etc.)
☐	Nosebleeds	☐	Headaches/Migraines
☐	Has begun menstruation	☐	Had surgery or hospitalized in the last 5 years
☐	Menstrual cramps	☐	Currently under doctor's care
☐	Bleeding disorder	☐	Emotional – Separation Anxiety
☐	Other:		

Please explain in detail all checked answers marked above:

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Participant Name: ______________________________

Allergies: Please list all allergies, the type of reaction and its severity, treatment and date of last reaction. Include allergies to medications, food, bees, animals, plants, etc.

Allergies	Reaction/ Severity	Treatment	Date of last Reaction
1.			
2.			
3.			

Does the participant suffer from Anaphylaxis? Yes No

*Anaphylaxis is a severe allergic reaction marked by swelling of the throat or tongue, hives, and trouble breathing.

Does the participant carry an EpiPen? Yes No

Does the participant carry asthma inhaler(s)? Yes No

Medical Conditions (including any precautions or restrictions on activities)

Name of Condition	Effects
1.	
2.	
3.	

Medications: List any medications the participant is currently taking (or has taken in the recent past) including dosage schedule and specific instructions for use. Also, please indicate (Yes/No) if minor is allowed to take the medication on her own or if she should be monitored by an advisor. This would include any type of birth control.

Medication	Purpose	Dosage Schedule	Specific Instructions	Self-Medicate? (Yes/No)
1.				
2.				
3.				
4.				
5.				

Over-the-Counter Medications: Does the participant have permission to take over-the-counter medications in case of accident or injury. Please check all that the participant has permission to take:

- ☐ Tylenol/Acetaminophen
- ☐ Aspirin (fever reducer)
- ☐ Ibuprofen (pain/swelling)
- ☐ Benadryl/Antihistamine
- ☐ Robitussin/expectorant
- ☐ Sudafed/decongestant
- ☐ Pepto Bismol
- ☐ Tums/antacid
- ☐ Imodium (anti-diarrhea)
- ☐ Dramamine (motion sickness prevention)
- ☐ Skin ointments (in case of rash, antibacterial, athlete's foot, etc.)
- ☐ Other: ______________________
- ☐ Other: ______________________

Special considerations or notes regarding over-the-counter medications:

Does the participant have a special medical or dietary regiment to be followed? Yes No

If so, please explain: ______________________________

Have the participant had any adverse reactions to general anesthetics? Yes No

If so, please explain: ______________________________

Any other information not covered in this form that is important that staff for this trip know: ______________________________

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Participant Name: ____

This section is to be completed by a licensed physician, nurse practitioner, physician's assistant or registered nurse.

Medical Examination – Must be completed in detail

Height: ______ Weight: ______ B. P.: _____/_____ Hearing: R ___ L ___
Eyes: With Glasses R 20/____ L 20/____ Without Glasses R 20/____ L 20/_____
Code: S = Satisfactory NS = Not Satisfactory NE = Not Examined

________ Nose	________ Abdomen	________ Urinalysis*	Other: ________________
________ Throat	________ Hernia	________ HGB*	______________________
________ Teeth	________ Genitalia	________ Appearance/Nutrition	______________________
________ Heart	________ Skin	________ General Physical State	______________________
________ Lungs	________ Musculoskeletal	________ General Emotional State	______________________

*Girls should have this test if she had not had it since entering puberty.

Record of Immunization – Must be completed in detail or attach a copy from doctor's office.
Personal and religious beliefs dictate against immunizations: Yes No

	Date Series was Completed	Year of Last Booster		Date Series was Completed	Year of Last Booster
Hep B	________	________	Typhoid	________	________
DTap/Tdap	________	________	Paratyphoid	________	________
DT/Td	________	________	Cholera	________	________
Hib	________	________	Yellow Fever	________	________
IPV/OPV	________	________	Typhus	________	________
PCV7	________	________	Rocky Mountain Spotted Fever	________	________
MMR	________	________	Tuberculin Test: Year last given		________ Result ________
Varicella	________	________			
Other:			Not required immunizations, but recommended		
__________	________	________	HPV	________	________
__________	________	________	Rota	________	________
__________	________	________	MCV4/MPSV4	________	________
__________	________	________	Hep A	________	________
__________	________	________	TIV/LAIV	________	________

Medical professional's information

Name: (First, Middle Initial, Last)	**Phone Number:**		
Address:	**City:**	**St:**	**Zip:**

*This person is in satisfactory condition and may engage in all usual activities, including physically demanding activities except as noted.

Signature of medical professional: ________________________ **State License Number:** _____________ **Date:** _______

HEALTH INFORMATION PRIVACY STATEMENT

The **Health History and Medical Examination Form** is for health care concerns at the specified event only. All records will be handled by staff/volunteers whose job includes processing or using this information for the benefit of the participant. All medical records will be held in limited access by the health care supervisor for the specific event. Minimal necessary information may be shared with event staff/volunteers in order to provide adequate participant safety and health care. This form will be retained for seven years past the age of maturity of the participant. Access to the information will be limited, but copies may be requested from the event sponsor, by the participant or their legal representative. I have read the above procedures for handling the health and medical form and I agree to the release of any records necessary for treatment, referral, billing or insurance purposes.

This Health History and Medical Examination Form is complete and accurate. My daughter has permission to engage in all prescribed activities, except as noted by me and the examining medical professional.

Signature of Participant (if adult) or Participant's Parent/Guardian (if participant is minor):

____ **Date:** ______________________