2020-21 PARTICIPANT INFORMATION AND HEALTH FORMS

To be completed for events where SEA staff are the primary caretakers of participants

Participant name: _____ **SEA member program:** _____

Participant cell phone: _____ **Sex:** _____ **Date of birth:** _____

☐ No participant cell phone

Parent/Guardian 1 name: _____

Relationship: _____
Cell phone #: _____
Home phone #: _____
Work phone #: _____

Parent/Guardian 2 name: _____

Relationship: _____
Cell phone #: _____
Home phone #: _____
Work phone #: _____

Home address: _____
Street & Apt City, State Zip Code

Emergency contact: If parents/guardian cannot be reached, please contact:

Name: _____ Relationship: _____ Phone: _____

Primary health care provider (doctor's name)**:** _____

Name of clinic/office: _____ Phone number: _____

Address: _____
Street & Apt City, State Zip Code

Health insurance company or policy name: _____ ☐ No insurance

Policy/ID #: _____ Group # (if applicable): _____

Does your child have **allergies**? **YES** **NO**

If yes, please describe: _____

Does your child have **any medical conditions**? **YES** **NO**

If yes, please describe: _____

Does your child regularly take **medication(s)****? **YES** **NO**

If yes, please describe: _____

*** If your child will take medication (prescription or over-the-counter) while in SEA's care, please complete the form on page 2 for each medication to be administered. This includes any medications that your child has permission to take as needed (Advil, Tylenol, etc.).*

Authorization for the Administration of Medication by SEA Program Personnel

Parents/guardians requesting that their child take medication (prescription or over-the-counter) while under SEA care must provide written authorization(s) before any medications are administered. Prescribed medication must be kept in the original container bearing the pharmacy label, which shows the date of filing, the pharmacy name and address, the filling pharmacist's initials, the serial number of the prescription, the name of the patient, the name of the prescription, and if tablets or capsules, the number in the container. Over-the-counter medications must be kept in the original containers containing the original label, which shall include the directions for use. Participants may only take medication when it is administered by the health supervisor or a licensed healthcare professional.

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed below.

Name of SEA Activity/Event _____ Dates of Event: _____

Name of Child _____ Date of Birth _____/_____/_____Today's Date _____/_____/_____

Child's Address _____ City, State _____

Name of Guardian Authorizing Administration of Medication _____

Relationship to Child (circle): Mother Father Other (explain): _____

Address _____ City, State _____Phone Number (_____) _____

➤ **Signature of Parent/Guardian** Authorizing Administration of Medication _____

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Medication Name _____ Controlled Drug? **YES NO**

Dosage _____ Method (oral, topical. etc.) _____ Time of Administration_____

Medication expiration date _____/_____/_____ Special Storage Requirements_____

Specific Instructions for Medication Administration _____

Medication Administration: Start Date _____/_____/_____ Stop Date _____/_____/_____

Specific Precautions _____

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug Allergies? **YES NO** Reactions to? **YES NO** Interactions with? **YES NO**

If "yes" to any of the above, please explain _____

Diagnosis (at parents' discretion): _____

Name of Licensed Prescriber_____ Phone Number (_____) _____

Licensed Prescriber's Address _____

****

Name of program personnel receiving written authorization and medication [FOR PROGRAM USE]

_____ _____ _____

Name & Title/Position Signature Date

PHYSICAL AND IMMUNIZATIONS REPORT

To be completed by a physician or nurse practitioner. This form may be substituted by submitting both (1) a list of immunizations from a doctor's office and (2) a copy of a physical examination completed within the past 18 months detailing medications, allergies and/or dietary restrictions, past medical treatments, and any physical, mental, or psychological conditions requiring medication, treatment, or special restrictions or considerations while in the program.

Participant full name: _____ Sex: _____ Date of birth: _____

Address (street, city, state): _____

Parent/Guardian Name(s): _____

Students are required to be immunized with the following. Please list specific dates for all immunizations or attach a form from the physician with this information.

Diphtheria, Tetanus, Pertussis (DTaP/DTP/DT/Td) (5): _____ _____ _____ _____ _____

Td/Tdap for grade 7 (age 12) thru college* (1): _____ Tetanus/diphtheria (td) Booster: _____
** Everyone else is required to have a dose of Tdap/Td if it has been more than 10 years since the previous dose of Td.*

Polio (OPV/e-IPV) (4):_____ _____ _____ _____
3 doses are acceptable if the 3rd dose is given on or after the 4th birthday and ≥6 months after the previous dose.

MMR (2): _____ _____OR Laboratory evidence of immunity

Hepatitis B (3): _____ _____ _____ OR Laboratory evidence of immunity

Varicella vaccine (2): _____ _____ OR – healthcare provider certified history of chickenpox disease.

Date of last complete physical exam:_____ *(must be within 18 months of SEA event)*

Height_____ Weight_____ Blood Pressure:_____/_____ Hct. or Hgb.:_____ TB test_____

Any significant illness or injuries since last physical exam? _____

General estimate of health:_____

Please list **medications** to be administered out while participating (including over-the-counter drugs):

_____

Please list **allergies and/or health conditions** such as asthma, etc., which may affect the student's activities:

_____

Name of health care provider:_____

Address of health care provider:_____

Health care provider phone:_____

Signature of examining physician/nurse practitioner:_____