Edgewood Consulting & Services
PO Box 122, New Paltz, NY 12561
(845) 255-7007

Please call if you have any questions about this form.
STAFF COMPLETE LIST ABOVE

Program Date: ___________
Program Type: __________
People in Group: _______
Location: ______________
MP Member: Yes or No
Other __________________

It is necessary that you disclose current health and relevant health history for your child. This information is necessary so in the unlikely event of an accident the staff person can assist your child. Please read this form carefully and fill it out accurately and completely. Everything is important. Completed medical forms must be received at least 10 days in advance.
Thank you for your cooperation. A parent or legal guardian must complete this form.

Medical History Questionnaire & Release for YOUTH

(participant younger than 18 years at time of registration)
(Confidential)

General Information:

Parent or Legal Guardian's Full Name: __________________________ Date:______________

Youth Participant's Full Name: ____
(First Name , Last Name)

Gender (circle one): Male or Female DOB: __________________ Age: _______

Height: _____________ Weight: _____________

Home Address: ____

Home Phone #: ______________________ Parent's Cell or Work #:______________________

Is the participant his/herself a member of the Mohonk Preserve? (circle one) Yes No

Emergency Contact Information:

Other Emergency Contact Person's Name: ____

Emergency Contact Person's Relationship to Participant: ______________________________

Phone Numbers for Other Emergency Contact: Home__________________________________

Work _________________________ Cell _______________________________

Home Address for Emergency Contact Person: _______________________________________

Medical Insurance Information:

Do you have medical health insurance that covers your child? Yes or No

If yes, with what company? Company's Name: ____________________________________

Policy Holder's Name: ____________________________ Policy #: ____________________

Primary Physician's Name: _________________________ Phone #s: ___________________

If you do not have insurance, please initial below that you acknowledge the risk of & will assume full responsibility for incurred medical expenses in the event that something happens to your child while participating in an Edgewood Consulting & Services Program that requires medical care. **Initial Here __________**

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Health Information:

In general how would you rate the youth's health overall?(circle one) Poor Fair Good Excellent

Does the participant wear contacts or glasses? (circle one) Yes No

Is the participant currently under the care of any doctor? (circle one) Yes No
If yes, please explain for what reason:

Is your child allergic to bees? (circle one) Yes No
If yes, does he/she need to carry an EpiPen? Yes No
If allergic to bees but no EpiPen is needed, describe the reaction:

List any other allergies & reaction (e.g., poison ivy, peanuts, other):

Is the participant currently taking any medication? (circle one) Yes No
If yes, please list name and dosage and explain for what reason:

If your child takes or uses medication, he\she will need to be responsible for bringing it on the day of the program and self-administering it. Program staff cannot medicate participants. Medication should be in a well-labeled container or bag that identifies the medication and dosage. Initial Here __________

Given your child's health history and current health, do you believe it is okay for him/her to participate in a program that involves rigorous outdoor activity for multiple hours such as hiking, snowshoeing, teambuilding, high challenge/ropes course program, or other? (circle one)
Yes No

Is there anything about your child's health that our staff person(s) should know? Yes or No
(chronic illnesses, physical conditions, injuries, etc.)

If yes, please explain:

Have you consulted with your personal family physician about your child's participation in a program with Edgewood Consulting & Services? (circle one) Yes No

If yes, did your physician say it is okay for him/her to participate? Yes or No

While consulting with one's physician is not required to participate in an Edgewood Consulting & Services program, we do strongly advise it, especially if one believes there is any reason why their personal physician might discourage participation or ask the participant to modify his/her level of activity or program choice. Initial Here _________

I hereby declare the information submitted in this document is truthful. And IN CASE OF MEDICAL EMERGENCY, I hereby give my permission to the emergency medical personnel or physician selected by an authorized representative of Edgewood Consulting & Services to secure proper medical treatment for my child, including, but not limited to, injections, anesthesia, surgery, and hospitalization. I understand I will be contacted as soon as possible.

_______________________________ ________________
Parent or Legal Guardian's Signature Today's Date