Medical Information

Name of Participant: ______________________________ Parent/Guardian Name (*if applicable)*:______________________

Birth Date: ______/______/______ Phone #: ____

Emergency Contact (Please circle the number to call first in an emergency)
Emergency Contact Name: __________________________________Relationship (optional): ________________________
Address:____
Phone #: _________________________ *(Home)* ________________________ *(Cell)* _____________________ *(Business)*

Personal Medical History List any allergies you have, including reactions to insect bites/stings, food allergies, and reactions or allergies to bug spray, sunscreen or other topical products that you (or your child/ward) have:

____

____

Have any of these allergies resulted in anaphylaxis? □ Yes □ No

-If yes, will you (or your child/ward) be bringing an epinephrine injector to the Cleveland Metroparks program? □ Yes* □ No

-Do you authorize Cleveland Metroparks staff to use your (or your child's/ward's), or another source if available, epinephrine injector (and, if necessary, Benadryl/Diphenhydramine) if you (or your child/ward) are suffering from anaphylaxis and are unable to self-administer the epinephrine? □ Yes □ No

Will you (or your child/ward) be bringing an inhaler to the Cleveland Metroparks program? □ Yes* □ No
Are you (or your child/ward) taking any medication(s) that will need to be administered during the program or may impact you/your child during the program? □ Yes □ No If yes, please list:

Medication/Dosage	Reason/Ailment
____	____
____	____

If nonprescription (including topical but excluding sunscreen, bug spray, hand sanitizer, or lip balm) or prescription medications are to be given to a minor during the program, complete the Request for Administration of Medication Form.*

Do you or your child have any medical conditions or other concerns that will impact your/your child's participation in the program or which you wish Cleveland Metroparks to know about? □ Yes □ No

If yes, please explain: ____

Do you (or your child/ward) require a special accommodation from Cleveland Metroparks for any reason in order to participate in the program? □ Yes □ No
If so, please describe the accommodation requested (minimum 72 business hours requested):
____

List any other history of medical problems or special circumstances we should be aware of:
____

Medical Insurance Company: ____
Physician: ____ **Phone #:** ____________________________________
Dentist: ____**Phone #:** ____________________________________

* If the answer to this question is yes for a minor in which the guardian isn't present, please complete the Request for Administration of Medication Form.