TRAIL LIFE USA

An additional medical form is **required** for Trail Life USA activities or events that exceed 72 hours in duration or include high altitude or high-exertion activities. That High Adventure Medical form requires the examination by and the signature of a doctor or health care professional.

YOUTH Weekend Health and Medical Record

Participant's Name _____ Date of birth _____ (MM/DD/YYYY) Age _____

Address _____ Grade completed _____

City _____ State _____ Zip _____ Phone # _____

Troop Leader _____ Troop# _____

Emergency Contacts:

Mother's Name _____

Home Phone # _____ Cell Phone # _____

Father's Name _____

Home Phone # _____ Cell Phone # _____

Other emergency contact if parents cannot be reached:

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

Health/accident insurance information:

☐ Member does not have health care coverage at this time (Please skip to next section – Physician Information)

☐ Member has health care coverage as listed below

Health/accident insurance company _____ Policy # _____

Policy Holder _____ Group # _____ Effective Date _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD.

Physician Information:

Primary Care Physician _____ Phone # _____

Physician's address _____

Dentist's name _____ Phone # _____

Preferred Hospital _____

ALLERGIES	Please list all known allergies including those to any medications, food and environment. If none are known, please write "none known". Attach additional page to this form if needed.
Allergy to:	Normal reaction and management of the reaction:

Full Name: _____ **Emergency Contact #:** _____

HEALTH HISTORY		Do you currently have, or have you ever been treated for any of the following?			
Yes	**No**	**Condition**			**Explain**
		Asthma	Last attack: (MM/YY)		
		Diabetes	Last HbA1c: (Percentage)		
		Hypertension (high blood pressure)			
		Heart disease/heart attack/chest pain/heart murmur			
		Stroke/TIA			
		Lung/respiratory disease			
		Ear/sinus problems			
		Muscular/skeletal condition			
		Psychiatric/psychological and emotional difficulties			
		Behavioral/neurological disorders			
		Bleeding disorders			
		Fainting spells			
		Thyroid disease			
		Kidney disease			
		Sickle cell disease			
		Seizures	Last seizure: (MM/YY)		
		Sleep disorders (e.g., sleep walking, sleep apnea)	Use CPAP?		
		Abdominal/digestive problems			
		Surgery	Last surgery: (MM/YY)		
		Serious injury			
		Excessive fatigue or shortness of breath with exercise			
		Other			

Full Name: _____ **Emergency Contact #:** _____

IMMUNIZATIONS	The following immunizations are recommended. **Tetanus immunization is required and must have been received within the last 10 years.** For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY).

Yes	No	Immunization	Date of Immunization (MM/YY)	Please indicate if you have had the disease		Date of Disease (MM/YY)
				Yes	No	
		Tetanus				
		Pertussis				
		Diphtheria				
		Measles				
		Mumps				
		Rubella				
		Polio				
		Chicken Pox				
		Hepatitis A				
		Hepatitis B				
		Meningitis				
		Influenza				
		Other (i.e., HIB)				
		Exception to immunizations claimed (form required)				

Full Name: _____ **Emergency Contact #:** _____

MEDICATIONS	List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. If none, please write "None" below.			
Medication	**Strength**	**Frequency**	**Approximate Date Started**	**Reason**

Administration of the above medications and such over-the-counter medications as may be deemed necessary for the health and safety of Participant is approved by (if required by your state):

_____ **and/or** _____

Parent/guardian signature **MD/DO, NP, or PA signature (where required by state law for the dispensation of medications by a non-parent)**

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You **SHOULD NOT STOP** taking any maintenance medication unless instructed to do so by your doctor.

No Trail Life youth member is allowed to self-medicate while participating in a Trail Life event. The only exceptions include emergency use medications such as by an inhaler, insulin syringe, or epi-pen, provided that the Trailman understands its proper use. Parents must indicate in writing that the youth is in possession of such medication and possesses the knowledge and ability to administer it to himself.

1. Emergency use medication authorized for self-administration_____
2. Emergency use medication authorized for self-administration_____
3. Emergency use medication authorized for self-administration_____

I do hereby attest that the youth participant is able to self-administer the above listed emergency use medications in case of emergency if no approved adult leader is present to administer.

_____

Parent/guardian signature

ADULTS AUTHORIZED TO TAKE YOUTH TO AND FROM EVENTS:

You must designate at least one adult. Please include a telephone number.

1. Name_____ Telephone _____
2. Name_____ Telephone_____
3. Name_____ Telephone_____

Adults NOT authorized to take youth to and from events:

1. Name_____ Telephone_____
2. Name_____ Telephone_____
3. Name_____ Telephone_____

Full Name: _____ **Emergency Contact #:** _____

I understand that, if any information I/we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

I give permission for full participation in Trail Life USA activities, except where specifically limited in writing herein.

This Health and Medical Record is correct and complete, as far as I know. I hereby give permission for Trail Life USA leadership to administer prescribed and over the counter medications.

In case of emergency, I understand every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission to the licensed health-care provider selected by the Trail Life USA adult leader(s) to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for my child, except as noted below. I agree to the release of records necessary for treatment.

Notes:

_____

_____

_____

Participant's signature		Date	
Parent/guardian's signature (if participant is under age 18)		Date	
Second parent/guardian signature (if required, for example, CA		Date	

This Weekend Health and Medical Record is valid for 12 calendar months.