

**Trinity Cathedral**  
**Medical Information and Consent to Treatment**

Participant and Parent/Guardian Information

Sponsoring Organization: **Trinity Cathedral**

Participant Name: \_\_\_\_\_  
Last First Middle

Dates of Attendance: **Aug. 20, 2010-Aug. 20, 2011**

Social Security No.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Gender:  Male  Female Birth date: \_\_\_/\_\_\_/\_\_\_

Age (at time of attendance) \_\_\_\_\_

Guardian Name: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address: \_\_\_\_\_

Work/Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_  
City State ZIP Code

Emergency Contact: \_\_\_\_\_

Phone Numbers: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Medical Information

Does the participant take any medication?  Yes (please describe below)  No

Please list any medications (including over-the-counter or non-prescription drugs) taken routinely. Bring enough medication to last the entire duration of the trip. Keep medications in their original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

Med #1 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #2 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Med #3 \_\_\_\_\_ Dosage \_\_\_\_\_ Specific times taken each day \_\_\_\_\_

Reason for taking \_\_\_\_\_

Does the participant have any allergies?  Yes (please describe below)  No

Does the participant have any medical history or restrictions that may limit participation or affect them while on trip?

Yes (please describe below)  No

Parent/Guardian Authorization & Acknowledgement of Risk

I give permission to the medical personnel selected by the leader of the trip or his designee to provide routine health care; to administer medications; order X-rays, routine test and treatment; to release any records necessary for insurance purposes; and to provide or to arrange necessary related transportation for my child. In an emergency, I give permission to the medical personnel so selected to secure and administer treatment including hospitalization for my child. I give permission for the photographs and/or audio/ video recording of my child to be used by the camp for its promotion, web site and/or news media coverage. I acknowledge that there are inherent risks to participation in recreational and adventure activities and programs sponsored by Trinity Cathedral, including but not limited to swimming, canoeing, climbing and ropes courses, which could result in accidental injury, possibly serious. Parents will be notified immediately if a problem is serious. Furthermore, engagement in these activities requires good physical condition on behalf of the participant. Being aware of the inherent risks and potential injury to my child, I hereby consent to my child's attendance and participation in the activities sponsored by Trinity Cathedral.

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Signature of Participant: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

(If more than 21 years of age)

**General Health Questions** (Please explain "yes" answers below.)

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?	<input type="checkbox"/>	<input type="checkbox"/>	16. Ever had back problems?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have a chronic or recurring illness/condition?	<input type="checkbox"/>	<input type="checkbox"/>	17. Ever had joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
3. Ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	18. Plan to bring an orthodontic appliance to trip?	<input type="checkbox"/>	<input type="checkbox"/>
4. Ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>	19. Have any skin problems?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>	20. Have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
6. Ever had a head injury?	<input type="checkbox"/>	<input type="checkbox"/>	21. Have asthma?	<input type="checkbox"/>	<input type="checkbox"/>
7. Ever been knocked unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	22. Had mononucleosis in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Wear glasses, contacts or eyewear?	<input type="checkbox"/>	<input type="checkbox"/>	23. Had problems with diarrhea or constipation?	<input type="checkbox"/>	<input type="checkbox"/>
9. Ever had frequent ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	24. Have problems with sleepwalking?	<input type="checkbox"/>	<input type="checkbox"/>
10. Ever passed out during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	25. If female, have an abnormal menstrual history?	<input type="checkbox"/>	<input type="checkbox"/>
11. Ever been dizzy during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	26. Have a history of bed-wetting?	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever had seizures?	<input type="checkbox"/>	<input type="checkbox"/>	27. Ever had an eating disorder?	<input type="checkbox"/>	<input type="checkbox"/>
13. Ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	28. Ever sought professional help with emotional difficulties?	<input type="checkbox"/>	<input type="checkbox"/>
14. Ever had high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>			
15. Ever been diagnosed with a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>			

If you marked yes to any of the above, please explain:

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Which of the following has the participant had?

- Measles
- Chicken Pox
- German Measles
- Mumps
- Hepatitis A
- Hepatitis B
- Hepatitis C

Which of the following immunizations has the participant had?

- DTP
- Polio
- TD (tetanus/diphtheria)
- MMR
- Measles
- Mumps
- Rubella
- Hepatitis B
- Varicella (chicken pox)
- Haemophilus influenza B

Date of last Tetanus shot \_\_\_\_\_

**Health Care Information**

Name of regular physician or health care facility \_\_\_\_\_ Phone (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Is the participant covered by an insurance plan?  Yes (please describe below)  No

Plan name: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Name of insured policy holder: \_\_\_\_\_ Relation to participant: \_\_\_\_\_

Policy ID number or Social Security number of policy holder: \_\_\_\_\_

Use this space to provide any additional information about the participant of which Trinity Cathedral and the trip's leaders should be aware: \_\_\_\_\_

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