aerie experiences
play... with a purpose

MEDICAL HISTORY - *To be completed by a parent/guardian*

Camper Name: _____

Physician's Name: _____

Address: _____

State: _____ Zip Code: _____

Telephone Number: _____ Mobile Number: _____ Fax Number: _____

Has the applicant had any of the following conditions? If so, please give dates:

- ☐ Allergies
- ☐ Anemia (low red blood)
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Problems
- ☐ Bladder/Kidney Infection
- ☐ Bone/Joint Condition
- ☐ Bronchitis
- ☐ Chicken Pox
- ☐ Convulsions or Seizures
- ☐ Deafness
- ☐ Dermatitis, Eczema
- ☐ Diabetes
- ☐ Enuresis (Bedwetting)
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Colds or
- ☐ Sore Throats
- ☐ Frequent Ear Infections
- ☐ Headaches (Migraine)
- ☐ Heart Disorder
- ☐ Hepatitis
- ☐ Kidney Problems
- ☐ Meningitis, Encephalitis
- ☐ Menstrual Irregularities
- ☐ Mononucleosis
- ☐ Muscle Weakness
- ☐ Pregnancy
- ☐ Problems with Bowel Habit
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Ulcers
- ☐ Venereal Disease (Herpes
- ☐ Gonorrhea, Syphilis)
- ☐ Vision Problems
- ☐ Other (Please explain)

Operations or serious injuries (dates and explanation):

Allergies or reactions to medications, food, insects, etc. (Indicate any dietary preferences, i.e. vegetarian, vegan, etc.):

Has the applicant had more than a brief minor illness or injury during the past year? ☐ **Yes** ☐ **No**
If yes, please explain:

Has the applicant ever been hospitalized? ☐ **Yes** ☐ **No**
If yes, for what and when:

Any medical restrictions of activity? **Yes** **No**
If yes, explain:

Blood type (If known):

List any medications and dosages the applicant is currently taking (prescription and non-prescription):

List any medications and dosages the applicant will need to continue taking during the course as well as times to be taken:

I DECLARE THE ABOVE STATEMENTS ARE COMPLETE AND CORRECT.

Applicant Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

EMERGENCY INFORMATION

In Case of Emergency, Contact: _____

Relationship to Participant: _____

Contact Phone #: _____ Email Address: _____

Address: _____

State: _____ Zip Code: _____

Alternative Contact: _____

Relationship to Participant: _____

Contact Phone #: _____ Email Address: _____

Address: _____

State: _____ Zip Code: _____

PHYSICAL EXAMINATION - *To be completed by a physician*

The individual stated below is being considered for participation in a 7-8 day therapeutic outdoor summer camp program. Participants will on occasion hike 3-4 miles per day and will participate in activities such as horseback riding, canoeing, swimming, backpacking, and other outdoor activities. Due to the nature of these activities, participants may become moderately dehydrated at times. The acceptance of this stated individual into our program is contingent upon your assessment of this individual's physical well-being, based upon a thorough examination and your opinion. We would appreciate your candid appraisal of this individual's health. If you are aware of any health reasons why this individual should not be involved in this program, please specify.

Applicant's Name: _____ Birth Date: _____ Exam Date: _____

Temp: _____ Pulse Rate: _____ Res Rate: _____

BP: _____ Height: _____ Weight: _____

Vision:

Without glasses: OD _____ OS _____ OU _____

With glasses: OD _____ OS _____ OU _____

Hearing: Audiometer screening test: ☐ Passed ☐ Failed

General Appearance-body build, behavior during physical, etc.:

Masculinity or femininity:	
Skin and hair:	
Head:	
Eyes:	
ENT:	
Mouth (including teeth):	
Neck:	
Lymph Glands:	
Chest:	
Lungs:	
Cardiovascular System:	
Abdomen:	
Genitalia:	
Tanner Stages of Development:	
Musculo-skeletal:	
Neurological (including mental status):	
Posture (spine-curvature):	
Personality: *(confident, tense, antagonistic, bragging, dependent, restless)*:	

General Appraisal (choose one):

☐ **Approval**: I find no medical condition(s) that I consider to be a risk to the physical well being of this individual while participating in a therapeutic outdoor program.

☐ **Disapproval /** Reasons:

Physician's Name (Please Print): _____

Physician's Signature: _____ Date: _____

Address: _____

Telephone Number: _____ Fax Number: _____

NOTE TO EXAMINING PHYSICIAN: *If you have questions concerning this individual's ability to successfully complete our program due to an unusual physical or medical condition, please contact our Director: Matthew Weneta, Aerie Experiences, 969 Golden Avenue, Dahlonega, GA (404) 285-067*

MEDICAL INSURANCE

Insurance Company: _____

Policyholder: _____

Policy #: _____ Subscriber #: _____

Employer, if Group Policy: _____ Group Policy #: _____

Type of Coverage: ☐ Outpatient ☐ Major Medical ☐ Hospital

Authorization for decisions regarding medical treatment to Aerie Experiences:
We, the undersigned, hereby authorize Aerie Experiences, or their representatives, to consult with psychologists, medical doctors, counselors, therapists, hospitals, or treatment programs and make any decisions necessary to care for the emotional or medical needs of this participant in the absence of consent on behalf of the parent/guardian or individual client.

Participant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____