SIU SOUTHERN ILLINOIS UNIVERSITY CARBONDALE
TOUCH OF NATURE ENVIRONMENTAL CENTER

PARTICIPANT MEDICAL AGREEMENT FORM

Name of Trip/Event _____

Dates:_____

PARTICIPANT INFORMATION

Participant's Name: _____ Nickname: _____

Permanent Address: _____

City, State, Zip: _____

Home/cell Phone: (____) _____ Work/Alternate Phone: (____) _____

Date of Birth: _____ Sex: _____ Grade (going into): _____

MEDICAL EMERGENCY CONTACT INFORMATION

Person to Contact First

Name: _____

Relation to Participant: _____

Daytime Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

Backup Contact (Relative or Friend)

Name: _____

Relation to Participant: _____

Daytime Phone: (____) _____

Cell Phone: (____) _____

Work Phone: (____) _____

SIU CARBONDALE SOUTHERN ILLINOIS UNIVERSITY
TOUCH OF NATURE ENVIRONMENTAL CENTER

Insurance Policy Information

☐Yes ☐No The above named participant is covered by health insurance.

If yes, please provide the following information which is required by Touch of Nature to expedite treatment and to facilitate the billing process.

Policy Holder's (P. H.)

Name: _____

Address: _____

_____

P. H.'s Date of Birth: _____

Relation to Participant: _____

Occupation: _____

Policy Holder Employer

Name: _____

Employers Address: _____

_____

Policy #: _____

Plan #: _____

Insurance Company

Name: _____

Address: _____

_____

Phone #: _____

MEDICAL INFORMATION FORM

Please circle YES (Y) or NO (N) to identify if you have had an incident or occurrence of any of the following in the last five years (attach another sheet if needed)

High Blood Pressure		Y	N		Intestinal Problems		Y	N	
Irregular heart beat		Y	N		Bladder infection		Y	N	
History of Hepatitis		Y	N		Kidney Problems		Y	N	
Bleeding disorder		Y	N		Hearing impairment		Y	N	
Epilepsy/Seizures		Y	N		Vision Impairment		Y	N	
Chronic headaches		Y	N		Sleep walking		Y	N	
Respiratory problems		Y	N		Neck or back problems		Y	N	
Asthma		Y	N		Shoulder problem		Y	N	
Diabetes		Y	N		Knee problem		Y	N	
Ankle problem		Y	N		Hand/foot problem		Y	N	
Hypoglycemia		Y	N		ADD/ADHD		Y	N	
Frostbite		Y	N		Intolerance to Cold/He		Y	N	

Other:_____

SIU CARBONDALE SOUTHERN ILLINOIS UNIVERSITY
TOUCH OF NATURE ENVIRONMENTAL CENTER

If yes was answered for any of the above items, please explain in the space provided:

_____

_____

Allergies?
(Include medicines, foods, bites/stings, etc.- when was last allergic reaction and what happened?)

_____

_____

_____

_____

_____

Medications? (List any and all medications you are currently using including over the counter products.) **Also identify <u>name</u>, <u>dosage needed</u> and how many times a day, what time(s) administered - bring an amount adequate for the length of the trip in the original containers with dosages**)

_____

_____

_____

_____

_____

Hospitalizations? (list all visits within the last two years, the date, and any treatment you received)

_____

_____

_____

_____

_____

NAME: _____

SIU CARBONDALE SOUTHERN ILLINOIS UNIVERSITY
TOUCH OF NATURE ENVIRONMENTAL CENTER

Dietary Needs/Restrictions?

_____

_____

_____

_____

_____

Do you feel that you are physically and mentally capable of participating in this camp? (A variety of environmental challenges may be encountered in our trip/event)

_____

_____

_____

Is there anything else that our staff needs to be aware of?

_____

_____

_____

You are responsible for any information that has been omitted or withheld from this form.

The information provided on this form is correct as far as I know.

Initial: _____

Date: _____

SIU CARBONDALE

SOUTHERN ILLINOIS UNIVERSITY
TOUCH OF NATURE
ENVIRONMENTAL CENTER

Authorization for Treatment

I hereby give permission to the medical personnel selected by Touch of Nature Environmental staff to order x-rays, routine tests, treatment and necessary transportation for me/or my child. I hereby give permission to the physician selected by the Instructional Staff to secure and administer treatment, including hospitalization for myself as named above. The completed forms may be photocopied for off-campus trips.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

NAME: _____