

MEDICAL INFORMATION & CONSENT

Part 1 - to be completed in full and signed by Parent/Legal Guardian (or Participant if 18 years or older).

The appropriateness of participation in a D.A.R.E. program will be determined based on the following information. Failure to complete the form in full may result in the participant not being in program.

PLEASE PRINT!

PARTICIPANTS NAME		DATE OF BIRTH		
		day	month	year
ADDRESS	CITY	POSTAL CODE		
HEALTH NUMBER	DENTAL COVERAGE AVAILABLE?	POLICY NUMBER		
	YES NO			
NAME OF FAMILY PHYSICIAN		TELEPHONE NUMBER(S)		
ADDRESS	CITY	POSTAL CODE		
IN CASE OF ILLNESS, PLEASE NOTIFY: NAME		RELATIONSHIP		
ADDRESS	CITY	POSTAL CODE		
HOME TELEPHONE NUMBER(S)		BUSINESS TELEPHONE NUMBER(S)		

A. PERSONAL HEALTH HISTORY (PLEASE BE SPECIFIC)

- | | | | |
|----|--|---|---|
| 1. | Bedwetting? (Acceptance will be based on severity of condition) How often? | Y | N |
| 2. | Sleepwalking? How often? | Y | N |
| 3. | Severe menstrual problems? (If applicable) | Y | N |
| 4. | Food or Drug allergies? (specify) Type of Reaction? | Y | N |
| 5. | Sight or hearing impairment, mentally handicapped? | Y | N |

B. IMMUNIZATION

All participants in an outdoor program **MUST** have up-to-date immunization. If in doubt, or if it has been more than 10 years, please arrange to see your doctor.

Date of most recent Tetanus/Polio/Diphtheria Booster: _____

C. MEDICAL CONDITIONS

If yes is checked for any of the following conditions in this Section C, a physician's exam **MUST** be completed and the Physician sign the Physician's statement on the reverse side of this form. Failure to check an area YES or NO will be taken as YES response and will require an exam by a Physician.

		YES	NO
1.	Epilepsy? Give details: What do the seizures consist of?	<input type="checkbox"/>	<input type="checkbox"/>
	How long since last seizure? Any medications?		
2.	Diabetes? (Special dietary requirements cannot be fulfilled)	<input type="checkbox"/>	<input type="checkbox"/>
3.	Symptomatic asthma, hay fever or other recurrent respiratory problems? Any medication? Indicate dosage: <i>*Please note: Allergy shots must be arranged and given by participant's Physician prior to or following the program they are registered in.</i>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Symptomatic heart disease impairing ability to participate?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Haemophilia?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Hepatitis or Jaundice?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Any severe problems of bones/joints/muscles likely to be aggravated by prolonged standing, running or hiking?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Recent illness, injuries or operations? Give details:	<input type="checkbox"/>	<input type="checkbox"/>
10.	Any other chronic illnesses, disabilities or limitations on physical activities?	<input type="checkbox"/>	<input type="checkbox"/>
11.	Medication or treatments taken regularly and to be continued while at camp? For what reason? Indicate dosage:	<input type="checkbox"/>	<input type="checkbox"/>
12.	Allergies: Any history of life threatening allergic reaction to common allergens... (eg. food, drugs, bees, other insects?) Specify:	<input type="checkbox"/>	<input type="checkbox"/>

Participants with known severe allergic reactions to bees/insects stings, resulting in anaphylactic shock (i.e. Difficulty in breathing or collapse will not be allowed in any programs between April 15 and October 1).

If in doubt about the type of reaction please have Physician note it here:

ACCEPTANCE OF PARTICIPANTS WITH KNOWN SEVERE ALLERGIC REACTIONS TO ALLERGENS OTHER THAN BEE/INSECT BITES; WILL REQUIRE CASE-BY-CASE CONSIDERATION. SPECIFY MENDICANTS AND/OR TREATMENT REQUIRED FOR REACTION:

Please have Physician review and complete the above in detail, and sign the Physician's statement in Part 3 on the reverse side of this form if a YES response is indicated in the above section.

Part 2 - Declaration and Authorization of Release of Medical Records (Please read carefully)

I certify that _____ is in good physical condition and capable of participating in a rigorous outdoor camping program, and that authority is granted for the participant to receive emergency medical and dental treatment, at any time, deemed appropriate.

I hereby authorize the release of medical records and information to/from Project D.A.R.E., to/from any Physician or medical facility that has provided or will be providing treatment for the above named participant.

I understand that each area must be checked YES or NO, and that a YES response or failure to check a response in Section C will be taken as YES and will require an examination by a Physician.

Date

Signature of Parent/Legal Guardian (or Participant if 18 yrs or over)

Please add any comments or other information that you feel may be helpful in caring for the participant or determining his/her appropriateness in a DARE program.

Part 3 - To be completed by Physician only if participant suffers from any conditions listed in Section C (Part 1)

To the PHYSICIAN - General Program Information (Please read carefully)

Project DARE is an outdoor program that operates in the wilderness in all types of weather. Accommodation is in tents. Participants will do their own cooking and special dietary requirements cannot be fulfilled.

The program activities may consist of hiking, cross country ski trips, canoe and sailing trips, or in-camp activities such as climbing and other high adventure activities. It should be understood that when on expeditions the participant may be several hours from emergency medical treatment.

Please comment on the condition(s) in Section C (Part 1) that brought this participant to your attention:

1. On the basis of the participant's medical history and present physical examination, do you feel that he/she is physically and psychologically capable of participant in a program at DARE? YES NO
2. How long have you known this participant?

Physician's Name (Please print)

Signature

Date

Address

City

Postal Code

Telephone Number(s):