MEDICAL INFORMATION FORM

Mail to: PO Box 336, Collinsville, CT 06022
Drop off: 41 Bridge St (Route 179), Collinsville

ONE PER PARTICIPANT

The information provided here will be held in the strictest confidence and will not be seen by any person or agency (excluding instructors/staff) except in the event of a medical emergency. The form must be completed for every CCK Kids Paddling School participant. CCK will destroy forms one week after the end of the program.

PARTICIPANT _____ **SESSION DATE** _____ [ ] **AM** [ ] **PM**

Date of Birth _____ Age _____ [ ] Male [ ] Female Height _____ Weight _____

Emergency Contact #1 _____

Relationship to Participant _____

Phone (H) _____ (W) _____ (C) _____

Emergency Contact #2 _____

Relationship to Participant _____

Phone (H) _____ (W) _____ (C) _____

Health Care Provider _____ Phone _____

Address _____

Health Insurance Company _____ Phone _____

Policy # _____ Subscriber Name _____

I, the undersigned, do hereby authorize instructors/staff of CCK to contact directly the person(s) named on this form, and do authorize these officials to contact the named health care provider(s) to render such treatment as may be deemed necessary in an emergency for the health of the participant named on this form. In the event that health care provider(s) or other person(s) named on this form cannot be contacted, or if distance or circumstances make it impractical for such person(s) to render direct medical assistance, the instructors/staff are hereby authorized to take whatever action is deemed necessary in their judgment for the health of the participant. This may include, but is not limited to, taking the participant to a hospital for treatment or making arrangements for the participant to leave the program for the purpose of visiting their health care provider for treatment. In all such cases the participant's parents/guardians are financially responsible for all medical treatment and transportation made in order to receive medical treatment. This form will be kept confidential from all persons at all times except the program instructor who will hold this form. I understand that this form will be shared with appropriate medical personnel in case of any medical situation that requires medical treatment.

Signature of Parent/Guardian _____ Date _____

1. **Medical**: Does the participant have any known medical conditions that would affect their functional ability to participate safely in the CCK Paddling School?

   [ ] No [ ] Yes, please explain:

2. **Allergies**: Does the participant have any allergies?

   [ ] No [ ] Yes, please explain:

   If allergic to bee/insect stings, may a sting kit be used in case of anaphylactic shock? [ ] No [ ] Yes

3. **Asthma**: Does the participant have asthma?

   [ ] No [ ] Yes, please describe how serious are attacks triggered by exercise:

4. **Diet**: Does the participant have special dietary requirements?

   [ ] No [ ] Yes, please describe:

5. **Heat**: Is the participant susceptible to problems associated with excessive heat?

   [ ] No [ ] Yes, please explain:

6. **Tetanus**: What was the date of the participant's last Tetanus shot?