ANCESTRAL KNOWLEDGE

PASSING ON ANCIENT LIFE WAYS

P.O. Box 6 • Brentwood, MD 20722 • Phone: (240) 832-5435 • www.ancestralknowledge.org

MEDICAL INFORMATION FORM

The information on this form is not part of the participant acceptance process, but is gathered to assist us in identifying appropriate care. Please inform Ancestral Knowledge staff of any changes to this information on or before the first day of the program. Providing complete and accurate information helps us to help you.

PARTICIPANT INFORMATION

Program Attending: _____ Program Date: _____

Name: _____ Date of Birth: _____
Last *First* *Middle Initial*

Age at Camp: _____ Gender: ☐ Male ☐ Female

Home Address: _____
Street/P.O. Box *City, State* *Zip*

CUSTODIAL PARENT/GUARDIAN INFORMATION

For participants under the age of 18

Name: _____ Name: _____
Address: _____ Address: _____
City, State, Zip: _____ City, State, Zip: _____
Home Phone: _____ Home Phone: _____
Cell Phone: _____ Cell Phone: _____
Work Phone: _____ Work Phone: _____

EMERGENCY CONTACT INFORMATION

If parent or guardian cannot be reached, the person listed below will be contacted in case of emergency.

Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City, State, Zip: _____ Relationship to Participant: _____

INSURANCE INFORMATION

Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No
If yes, carrier or plan name: _____ Group #: _____
Name of Insured: _____ Relationship to Participant: _____
Insurance ID #: _____
Carrier address: _____
Street/P.O. Box *City, State* *Zip*

AUTHORIZATION

This health history is correct and complete as far as I know, and the person herein described has permission to engage in all camp activities unless otherwise noted.

I hereby give permission to Ancestral Knowledge to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. I give permission to Ancestral Knowledge to arrange necessary related transportation for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by Ancestral Knowledge to secure and administer treatment, including hospitalization, for the participant.

Signature of parent/guardian (*for participants under the age of 18*) or adult participant: _____

Print Name: _____ Date: _____

ALLERGIES

Please list all allergies including insect stings, hay fever, animal dander, asthma, etc…	Please describe reaction and management of the reaction. To list additional allergies, please attach a page describing the allergy, reaction, and management of the reaction using this format.
Medications:	
Food:	
Other:	

MEDICATIONS

☐ The participant takes NO MEDICATIONS on a routine basis. ☐ The participant takes medication as follows:

Med #1: _____ Dosage: _____ Specific Times Taken Daily: _____
Reason for Taking: _____

Med #2: _____ Dosage: _____ Specific Times Taken Daily: _____
Reason for Taking: _____

To list additional medications, please attach a page describing medications taken, dosage, times, and reason using the above format.

RESTRICTIONS

Does not eat (*check all that apply*): ☐ Meat ☐ Dairy ☐ Seafood ☐ Eggs ☐ Other (describe): _____
Please explain any restrictions to activity (*what cannot be done, what adaptations or limitations are necessary*): _____

GENERAL HEALTH QUESTIONS

Has/does the participant:	Yes	No		Yes	No
1. Had any recent injury, illness or infectious disease?			15. Unable to swim?		
2. Have a chronic or recurring illness/condition?			16. Ever had back problems?		
3. Ever been hospitalized?			17. Ever had problems with joints?		
4. Ever had surgery?			18. Bringing an orthodontic appliance to the program?		
5. Have frequent headaches?			19. Have any skin problems?		
6. Ever had a head injury?			20. Have diabetes?		
7. Ever been knocked unconscious?			21. Have asthma?		
8. Wear glasses, contacts or protective eye wear?			22. Had mononucleosis w/in the year?		
9. Ever had frequent ear infections?			23. Had problems w/ diarrhea/constipation?		
10. Ever passed out during or after exercise?			24. Have problems with sleep walking?		
11. Ever been dizzy during or after exercise?			25. If female, have an abnormal menstruation?		
12. Ever had seizures?			26. Have a history of bed-wetting?		
13. Ever had chest pain during or after exercise?			27. Ever had an eating disorder?		
14. Ever had high blood pressure?			28. Ever sought professional help for emotional difficulties?		

Please explain any "yes" answers, noting question numbers: _____

Which of the following has the participant had?: ☐ Measles ☐ Chicken Pox ☐ Mumps ☐ German Measles ☐ HepA ☐ Hep B ☐ Hep C

Is the participant current on all immunizations?: ☐ Yes ☐ No, please explain: _____

Use this space to provide any additional information about the participant's behavior and physical, emotional, and mental health about which Ancestral Knowledge should be aware. _____

Name of family physician: _____ Phone: _____
Name of family dentist/orthodontist: _____ Phone: _____

Participant Name: _____
Last *First* *Middle Initial*