

MEDICAL INFORMATION 2018

Go Palestine

To be Completed by a Parent or Guardian of the Trip Participant

PLEASE COMPLETE & RETURN AS SOON AS POSSIBLE TO: gopalestine@rfs.edu.ps

Note: The following medical and contact information may be necessary in the unlikely event of illness or accident. The facts you disclose will be kept confidential and will only be used by The Ramallah Friends School office and the program staff to respond to an injury or illness. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness.

PART I: CONTACT INFORMATION

Participant's Name: _____

Program: _____ Program Dates: _____

Date of Birth: _____ Gender: Male Female

Address: _____ City: _____ State/Province: _____

Country: _____ Zip or other code: _____ Home Phone # _____

Person(s) we should contact FIRST in case of an emergency: _____

Name of Custodial Parent: _____ (check one): Mother Father Guardian

Work Phone # _____ Cell Phone # _____

Second Parent: _____ (check one): Mother Father Guardian

Work Phone # _____ Cell Phone # _____

****Alternate Emergency Contact Person:** _____

Relationship to Participant: _____

Phone# _____ Alt. Phone # _____

Address _____ City, State, Zip _____

PART II: INSURANCE AND PROFESSIONAL INFORMATION

Please indicate your hospitalization information for emergency use.

Is the participant covered by travel medical/ hospital insurance? NO YES

If yes, please indicate the following information:

Insurance carrier or plan name: _____ Policy #: _____

Group Policy #: _____

Address of Carrier: _____

Name of family physician: _____ Phone # _____

Name of family dentist: _____ Phone # _____

PART III: PARTICIPANT MEDICAL HISTORY

1A. Is your son/daughter currently taking any medications on a regular basis?

__ NO

__ YES: If so, please list ALL medications (including over-the-counter or nonprescription drugs) your child has taken routinely in the past 3 months. (Please attach any additional information).

Medication	Taken For (Condition/Symptom)	Dosage (Size/Frequency)	Date Started	Current Side Effects (if any)

NAME: _____ PROGRAM: _____

1B. If your son/daughter is currently taking routine medications? Do you plan to have your son/daughter continue to take these medications during the program? YES NO: If no, please explain:

1C. If your son/daughter is planning on taking routine medications during the program, who will be responsible for handling and administering the medications:

- My child will be responsible for administering his/her own medication(s) &/or vitamins
 I prefer the Go Palestine staff to hold onto my son/daughter's medications and disperse them as prescribed.

2. Does your son/daughter have any known allergies (including medication allergies, food allergies, or other)?
 NO YES

Type	Describe reaction and appropriate management of reaction (please use addition sheet if necessary)

3. Has your son/daughter ever been diagnosed with any mental health conditions?
 NO
 YES If yes, please describe:

4. Does your son/daughter have any dietary restrictions we should know about?

6. Has your son/daughter ever had any history of the following? (Please check corresponding circle if there is a history.)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Phobias (claustrophobia, etc.) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Eating Disorders |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Anorexia Nervosa |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Recurrent | <input type="checkbox"/> Bulimia |
| <input type="checkbox"/> Cramps | <input type="checkbox"/> Neck Problem | <input type="checkbox"/> Dental Problems | <input type="checkbox"/> Emotional difficulties for which professional help was sought |
| <input type="checkbox"/> Diarrhea/ | <input type="checkbox"/> Shoulder Problem | <input type="checkbox"/> Lymes Disease | <input type="checkbox"/> Wears glasses, contacts, or protective eye we |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Knee Problem | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Gastrointestinal Problem | |
| <input type="checkbox"/> Recent injuries of any kind | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Heart Problems | |
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | |

Please explain any checked item(s) on a separate piece of paper if necessary.

PART IV: PARENTAL CONSENT *Important- this box must be complete for enrollment in program.

<p>PARENT/GUARDIAN AUTHORIZATION: This health history is correct and complete as far as I know. The participant herein described has permission to engage in all program activities except as noted. I hereby give permission to Ramallah Friends School 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 treatment, referral, billing, or insurance purposes. It is understood that in case of emergency, Ramallah Friends School will make every reasonable attempt to immediately contact this participant's parent(s) or guardian(s). In the event I cannot be reached in an emergency, I hereby give permission to the licensed physician selected by Ramallah Friends School to secure and administer treatment, including hospitalization, injections, anesthesia or surgery, for my child. This completed form may be photocopied for use of staff in the field.</p>	
Parent/Guardian Signature _____	Date _____
Printed Name _____	Additional Notes Attached: _____