



# Youth (under 18) Medical-Diet Information Form

(CONFIDENTIAL - FOR STAFF/ADMINISTRATION USE ONLY)

Participant's Name: \_\_\_\_\_  Male  Female Date of Birth: \_\_\_\_\_  
 Trip/Program: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian's Name(s): \_\_\_\_\_

Contact Phone Number: (#1) \_\_\_\_\_ (#2) \_\_\_\_\_  
 Address: \_\_\_\_\_

Additional Contact(s) : \_\_\_\_\_  
 Phone Number: (#1) \_\_\_\_\_ (#2) \_\_\_\_\_

Health Care Provider: \_\_\_\_\_ Health #: \_\_\_\_\_  
 Doctor's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

| Overview: 1=weak & 5=excellent | Comments |
|--------------------------------|----------|
| General health                 |          |
| Level of Fitness               |          |
| Swimming ability               |          |

Health Conditions – Please describe any health conditions that may affect your child's participation.  
 ie asthma, susceptible to cold, joint pains, fainting, ear aches, headaches, sleepwalking

Allergies: - Please detail any allergies, reactions and treatment  
 ie anaphylactic reaction to bee stings – carries an anakit

Medications – Please detail all medications, when and how they are taken.

Dietary – Detail any dietary restrictions and preferences  
 ie: peanuts & dairy restriction ~ likes or dislikes mashed potatoes

Behavioral – Detail any behavioral/mental health problems how we can best deal with them.  
 Is there anything else you would like us to know about your child?

Signed by parent/ guardian for youth under 18 \_\_\_\_\_ Date \_\_\_\_\_