Rippleffect

2017 Health and Registration Form

Participant Information

Name of participant: _____ Date of birth: _____ Male_____ Female _____

Age at time of program: _____ School:_____ Grade at time of program: _____

(If under 18) Parent/Guardian Name(s): _____Relation to Participant: _____

Address: Street_____ City_____ State_____ Zip _____

Home Phone: _____Work Phone: _____Cell: _____

Email: _____ Program Name and Dates of Registration: _____

General Health History

Please be as thorough as possible!

Rippleffect will not be held liable for any injury or illness resulting from any undisclosed medical conditions.

PAST HISTORY	Comments	**CONDITIONS**	Comments	**ALLERGIES**	Comments
Heart History		Asthma/ Shortness of breath		Latex	
Ears: Infections/ Hearing Loss/ Deafness		Diabetes/ Low Blood Sugar		Poison Ivy	
Eyes: Impaired vision/ Blindness		Epilepsy/ Seizures		Hay fever / pollens	
Fainting or dizziness		Mental Health: Type/Medication/ Supervision		Food allergies: Type/name/ Epi-pen carried?	
Chest pain		Back or joint problems		Insect Stings: Epi-pen carried?	
Bed wetting		Uncontrolled bleeding/ Hemophilia		Allergies to medicine: Type/name	
Hospitalizations or surgeries		ADD or ADHD		Others; please explain	
Others; please explain		Others; please explain			

Are there any other medical conditions, physical limitations or recurrent injuries or illnesses that may restrict participation? If so, what are they? _____
_____
_____

Please use space provided below or on the back to explain any treatment or explanation of any of the above: _____
_____

Special Diet Needs or Restrictions: _____

Medication: ☐ This participant WILL NOT take any medications while attending this program

☐ This participant will take the following medications during the program:

Please send all medications in original pharmacy containers with labels which show the participant's name and how the medication should be given. Provide enough medication to last the duration of the program. Rippleffect staff will administer medications.

Name of medication	**Date started**	**Reason for taking it**	**When it is given (specify time of day)**	**Amount or dose given**	**How it is given**

(Form continues on back)

Rippleffect

Participant Name:_____ Program Name:_____

The following non-prescription medications are used by Rippleffect on an *as needed basis* to manage illness and injury. **Please cross out any of these medications that the participant should *NOT* be given.**

Acetaminophen (Tylenol)	Glucose tablets	Antibiotic cream
Antihistamine (Benadryl)	Ibuprofen	Aloe
Antacid (Pepto or Tums)	Technu (Poison Ivy prevention)	Zinc oxide

Emergency Contact Information:

Primary Emergency Contact Name: _____Relationship: _____
Daytime Phone: _____Evening Phone: _____Cell phone: _____

Secondary Emergency Contact Name: _____Relationship: _____
Daytime Phone: _____Evening Phone: _____Cell phone: _____

Primary Care Provider (PCP) Name, Phone Number and Address: _____
_____

Insured? □ Yes □ No

Provider Name:_____

Provider Phone Number:_____ Policy Number:_____

Subscriber Name:_____ Subscriber Date of Birth:_____

This health history is correct and accurately reflects the health status of the named participant.

Signature of participant: _____ Date: _____
(For participants under 18 years of age)
Signature of parent/legal guardian: _____ Date: _____

For participants under 18 who self-administer emergency medication:

I verify that _____ (participant's name) has the knowledge and skills to safely self-administer the following emergency medication as necessary:_____. I give permission for him/her to self-administer this medication whenever necessary during the Rippleffect program.

Signature of Primary Care Provider:_____ Printed Name:_____
Signature of parent/legal guardian:_____ Date:_____