



# Participant Information Form

To be filled-out by a Parent

Name (Last, First): \_\_\_\_\_ Program: \_\_\_\_\_

Preferred Email address: \_\_\_\_\_

In case of emergency contact: (1) \_\_\_\_\_ Phone: \_\_\_\_\_

(2) \_\_\_\_\_ Phone: \_\_\_\_\_

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## Medical History

What do you want us to know about your Participant? \_\_\_\_\_

Any food allergies? Please explain: \_\_\_\_\_

How about insect bites, plants? Please explain: \_\_\_\_\_

Or, drug allergies? Please explain: \_\_\_\_\_

Is your Participant currently taking any medications? NO YES

Name of Medication/Purpose \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Insurance Carrier and Policy Number \_\_\_\_\_

Health History (check all that apply with approximate dates):

- |  |   |
|--|---|
| <input type="checkbox"/> Asthma/Respiratory Problems | <input type="checkbox"/> Heart Problems         |
| <input type="checkbox"/> Muscle-Skeletal Problems    | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Seizures                    | <input type="checkbox"/> Hypertension           |
| <input type="checkbox"/> Knee/shoulder problems      | <input type="checkbox"/> Back injuries/problems |
| <input type="checkbox"/> Penicillin                  | <input type="checkbox"/> Tetanus vaccine        |
|  | <input type="checkbox"/> Other Medical Problems |

## Emergency Authorization

I hereby grant permission to Peak Experiences Staff or other Emergency Medical Personnel to render emergency or first aid treatment for any and all illnesses and injuries to the above named participant.

Parent or Guardian Signature \_\_\_\_\_ Date: \_\_\_\_\_

**THANK YOU.**