



# COTTONWOOD GULCH EXPEDITIONS

## School Group Participant Info & Health History Form

COMPLETE, SIGN & RETURN TO: COTTONWOOD GULCH, 9223 4th St. NW, ALBUQUERQUE, NM 87114

GROUP \_\_\_\_\_ SLEEPING BAG RENTAL NEEDED: \$5/night Y / N  
 TREKKER NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_  
 PARENT(S)/GUARDIAN(S): \_\_\_\_\_  
 HOME ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 BUSINESS ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
 HEALTH INSURANCE? YES/NO (CIRCLE ONE) INSURANCE COMPANY \_\_\_\_\_ ID # \_\_\_\_\_  
 GROUP # \_\_\_\_\_ NAME OF PRIMARY INSURED \_\_\_\_\_  
 IF UNAVAILABLE IN AN EMERGENCY, CAMP SHOULD NOTIFY: #1 \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_  
 IF UNAVAILABLE IN AN EMERGENCY, CAMP SHOULD NOTIFY: #2 \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_  
 PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_ CELL: \_\_\_\_\_

### PARENT AUTHORIZATION TO PROVIDE MEDICAL TREATMENT

THE HEALTH HISTORY DESCRIBED BELOW IS CORRECT SO FAR AS I KNOW, & THE PERSON DESCRIBED HEREIN HAS PERMISSION TO PARTICIPATE IN ALL PRESCRIBED ACTIVITIES EXCEPT AS NOTED BY ME & THE EXAMINING PHYSICIAN. IN THE CASE THAT I CANNOT BE REACHED IN AN EMERGENCY I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL/PHYSICIAN SELECTED BY THE COTTONWOOD GULCH FOUNDATION, OR ITS EMPLOYEES, TO HOSPITALIZE, SECURE PROPER TREATMENT FOR, & TO ORDER INJECTION, ANESTHESIA, OR SURGERY FOR MY CHILD AS NAMED ABOVE:

SIGNATURE OF PARENT OR LEGAL GUARDIAN (if minor): \_\_\_\_\_ DATE: / /

HEALTH HISTORY TO BE COMPLETED BY PARENT (PLEASE INCLUDE APPROXIMATE DATES AND DETAILS OF ILLNESS/INJURY):

MUSCULOSKELETAL INJURIES (RESOLVED?) \_\_\_\_\_  
 ALLERGIES, SENSITIVITIES \_\_\_\_\_  
 HEAD INJURIES, CONCUSSION, KNOCKED UNCONSCIOUS (RESOLVED?) \_\_\_\_\_  
 SKIN PROBLEMS \_\_\_\_\_  
 ASTHMA OR OTHER BREATHING PROBLEMS? \_\_\_\_\_  
 HAS YOUR CHILD BEEN STUNG BY A BEE? YES / NO (CIRCLE ONE) REACTION? \_\_\_\_\_  
 DIABETES \_\_\_\_\_  
 HEART CONDITIONS? \_\_\_\_\_  
 SERIOUS MEDICAL CONDITIONS, INFECTIONS \_\_\_\_\_  
 OPERATIONS OR HOSPITALIZATIONS \_\_\_\_\_  
 DISABILITY OR CHRONIC/RECURRING ILLNESS \_\_\_\_\_  
 PSYCHIATRIC TREATMENT OR COUNSELING \_\_\_\_\_  
 LEARNING CHALLENGES/ SPECIAL SERVICES RECEIVED DURING THE SCHOOL YEAR \_\_\_\_\_  
 CURRENT MEDICATIONS (NAME, FREQUENCY, DOSE AND REASON) \_\_\_\_\_  
 \_\_\_\_\_  
 FOR FEMALES: FIRST MENSTRUAL PERIOD \_\_\_\_\_ LAST MENSTRUAL PERIOD: \_\_\_\_\_  
 OTHER HEALTH INFORMATION THAT MAY BE HELPFUL TO OUR STAFF (USE ADDITIONAL SHEET IF NEEDED) \_\_\_\_\_  
 \_\_\_\_\_

### IMAGE RELEASE

I, \_\_\_\_\_, THE PARTICIPANT (OR LEGAL GUARDIAN OF THE CHILD) LISTED ABOVE, HEREBY GRANT THE COTTONWOOD GULCH FOUNDATION PERMISSION TO USE MY CHILD'S PHOTOGRAPHIC IMAGE, AUDIO AND VIDEO RECORDED LIKENESSES, AND WRITTEN MATERIALS FOR USE IN ITS PROMOTIONAL MATERIALS. THIS USE MAY INCLUDE, BUT IS NOT LIMITED TO, THEIR BROCHURE, WEB SITE, FOUNDATION REPORTS AND NEWSLETTERS, PRESS RELEASES, PROMOTIONAL AND ARCHIVAL AUDIO AND VIDEO RECORDINGS AND RECRUITING PRESENTATIONS.

SIGNATURE OF PARTICIPANT (or parent/guardian-minors): \_\_\_\_\_ DATE: / /

IMPORTANT: PLEASE NOTIFY THE DIRECTOR IF THIS CAMPER IS EXPOSED TO ANY COMMUNICABLE DISEASES DURING THE THREE WEEKS PRIOR TO THE START OF THE SESSION.