Clinical Connections

**SpeechKids/ OT Kids
Play Partners**

**Jamberry Center
Classroom Connection
Culture Club
North Shore Teen Center
Transition Connection**

**

2219 Lakeside Drive

Bannockburn, IL 60015

847/234-0688 voice

847/234-0687 fax

**Outing Trip Health Form**

(Mandatory for student and multi-day adult participants)

This form grants temporary authority to a designated adult to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This form should accompany the child in the event of off-site trips or emergency relocation of the program.

Trip Date \_\_ / \_\_ / \_\_

**Participant Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Last First

**Date of Birth:** \_\_\_\_­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_ ­**Sex:** F / M **Home Phone:** ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­

**Home Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_**State:** \_\_\_\_ **Zip:**\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Wk Phone:** ( )\_\_\_\_\_\_\_\_ **Cell Phone:** ( )\_\_\_\_\_\_\_\_\_\_

(minor participants only)

|  |
| --- |
| **In an emergency, please notify:** ☐ Check here if same as above.**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Work Phone: ( ) \_\_\_\_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_\_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_\_\_\_\_\_\_****Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Health History**

1. Check all allergies participant my have and briefly describe the reaction:

☐ Insect stings/bites \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Seafood \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Asthma (allergy induced) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Food (wheat/nuts) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Hay Fever\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ Penicillin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Check below if participant currently has or has had any of the following:

**CONDITION Past Currently Has**

Heart Defect/Disease ☐ ☐

Diabetes ☐ ☐

Hypertension ☐ ☐

Epilepsy ☐ ☐

Bleeding/Clotting Disorders ☐ ☐

Asthma ☐ ☐

Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ ☐

2. Complete the following:

a. Are there any specific activities to be encouraged, limited or avoided? ☐ YES ☐ NO

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Do you/your child have any special dietary considerations? ☐ YES ☐ NO

If yes, please provide detailed information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

g. Provide any other important health related information about yourself/your child:\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Complete the following:

a. What is the name of the participant’s physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. What is the name of location of practice of the participant’s physician? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. What is the physician’s phone number? ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. What is the participant’s medical insurer/health plan and policy number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e. Please note all conditions for which the child is currently receiving treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

f. Note any other significant medical information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Read and sign the following:**

1) This health history provided in this document is correct so far as I know. I understand that participation in this outing club is entirely voluntary. I understand that the field trip may involve: sledding, tubing, ice skating, hiking, fishing and other outdoor activities. I understand that participation in outing involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct. With appreciation of the dangers and risks associated with the outing and activities, on my own behalf and/or on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against Clinical Connections, its affiliates, and their owners, officers, directors, employees, contractors, and volunteers in connection with the outing, including without limitation, in connection with any medical treatment provided to my child. I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered as part of the outing.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature or adult participant signature Date

2) I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for Clinical Connections staff to administer general first aid treatment for any minor injuries or illnesses experienced by my child. In case of an emergency involving my child, I understand that efforts will be made to contact the individual listed as the emergency contact person by the medical provider and/or Clinical Connections staff. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by Clinical Connections Staff to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to Clinical Connections staff, and/or any physician or health-care provider involved in providing medical care to my child. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the child, follow-up and communication with the child’s parents or guardian, and/or determination of the child’s ability to continue in the outing activities. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of Clinical Connections in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/guardian signature or adult participant signature Date

This authorization is effective through \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_.

Printed name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_