**Conservation Youth Corps**

**Youth Medical History - Please complete only if youth has a medical problem or allergy.**

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| --- | --- | --- | --- |
| First Name Last Name Date of Birth (DD/MM/YYYY)   |  |  |  | | --- | --- | --- | |  |  |  | |
| **Please indicate all the weeks you participate.** |
|  |
| Primary Contact  Name Address   |  |  | | --- | --- | |  |  |   Phone (H) (C) (B)   |  |  |  | | --- | --- | --- | |  |  |  | |
| Emergency Contact  Name Address   |  |  | | --- | --- | |  |  |   Phone (H) (C) (B)   |  |  |  | | --- | --- | --- | |  |  |  | |
| Physician’s Name Phone   |  |  | | --- | --- | |  |  | |
| Dentist’s Name Phone   |  |  | | --- | --- | |  |  | |
| **Allergies Other Heath Concerns**   |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | * Food (ALGF) * Drug (ALGD) * Insect bite (ALGI) * Carries Epipen (EPIP) * Carries Asthma Inhaler   Please list specific allergies food/drugs/insects   |  | | --- | |  |   Please list type of reaction that occurs (ie. Rash, swelling, difficulty breathing etc.)   |  | | --- | |  | | Is the participant under any form of treatment/medication for any illness, condition or injury?   * No * Yes, please explain:  |  | | --- | |  |  * Diabetic (DIBT) * Epilepsy/Convulsions (EPLC) * Emotional/Behavioural (EMOB) * Asthma (ASTH) * Injury (INJR) * Other (MEDO), please explain:  |  | | --- | |  | | |

**Prescription Medication Record**

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| --- | --- |
| Name of Medication: | Date Medication Prescribed: |
| Expiration Date: |
| Instructions for Administering: | Date/Time of First Dose: |
| Completion Date: |
| Times and Dosage Given By Parent/Guardian: | Times and Dosage to be Given at Program: |
| Common Side Effects and Recommended Action: | Precautions/Other Comments: |

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| --- | --- | --- | --- |
| Instructions for Storage of Medication: | | | |
| I request that medication be administered for my child as stated above and hereby release Toronto and Region Conservation Authority (TRCA) and anyone else acting on this request from all claims for any loss or injury that may result.  Parent’s/Guardian’s Name ( Please Print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent’s/Guardian’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| **Dispensing Record** | | | |
| **Date Given** | **Time Given** | **Amount Given** | **Administered by: (Signature)** |
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