

KROKA EXPEDITIONS PHYSICAL, MEDICAL & EMERGENCY INFORMATION

767 Forest Road, Marlow, NH 03456 / phone 603.835.9087 / fax 603.835.6738/summer@kroka.org/www.kroka.org

- **NOTE: You MUST attach a doctor's form to this questionnaire indicating your child has received a physical examination within the past 2 years. It must have a doctor's signature.**
- **Please do not leave any questions blank. Mark "none" or "no" if a question does not apply. This form contains important information to help us work with your child. Incomplete forms will be returned.**
- **Please note the information on this form is kept strictly confidential.**

Student Name _____ Birth date ____/____/____

Program Name _____

Allergies (Please bring an EpiPen if allergic to bee stings)? _____

Please rate the severity of the above allergies: mild moderate severe (life threatening)

Please describe in detail allergic reaction _____

Dietary Restrictions _____

Is student taking any medication? YES / NO If yes, what kind(s) _____

For what conditions _____

Instructors administer all medications unless other arrangements are made. Please provide written instructions below regarding dosage, frequency and potential side effects. These instructions will be taken on the trip and followed by staff. Please be specific. Please use additional paper if needed.

MEDICAL EMERGENCY INFORMATION

Doctor's Name _____ Office Phone _____

Medical Insurance Carrier* _____ Phone _____

Medical Insurance Policy Number _____

****If you are uninsured, please read and sign the following:***

Having no insurance, I assume all financial responsibility for the cost of any medical treatment that may be a result of my child's participation in a Kroka Expeditions' program.

Signature _____

Date ____/____/____

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EMERGENCY CONTACT INFORMATION (while your child is at camp). Please print clearly.

1. Mother's Name _____ Day phone #(_____) _____
Night phone #(_____) _____ Cell phone# (_____) _____
2. Father's Name _____ Day phone #(_____) _____
Night phone #(_____) _____ Cell phone# (_____) _____

You MUST provide the name & phone number of an emergency contact, in case you are unreachable:

1. Name _____ Home phone#(_____) _____
Relationship _____ Cell phone#(_____) _____

I hereby give permission for any emergency treatment, should it become necessary.

_____ Date ____/____/_____
Signature of parent or guardian for students under 18 years old

Please use additional paper, if needed.

If applicable, has your daughter started menstruating? _____

Does your child have any history of Urinary Tract Infections? _____

Describe your child's appetite, a favorite food and an absolutely not favorite food. _____

List any past or current conditions that may limit student's participation in any activity. _____

Are you or your child concerned about being homesick, if so, to what degree and please describe any specifics. _____

How does your child deal with stress and get along with other people? _____

We would like to know anything unique/special/different about your child that may affect this experience for her/him, other students, or staff. With staff knowledge prior to the program, the experience for all, most importantly your child, will be much more enjoyable.