



B-Ball for Life Foundation, Inc.

HBCU TRIP HEALTH FORM

(Mandatory for student and multi-day adult participants)

Trip Date ___ / ___ / ___

Participant Name: _____

Last

First

Age: _____ **Sex:** F / M _____ **Home Phone:** () _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Family Physician: _____ **Office Phone:** () _____

Insurance Company: _____ **Policy # / ID #:** _____

Parent/Guardian: _____

Work Phone: () _____ **Cell Phone:** () _____

(minor participants only)

Health History

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

- Insect stings/bites _____
- Asthma (allergy induced) _____
- Hay Fever _____
- Other _____
- Seafood _____
- Food (wheat/nuts) _____
- Penicillin _____

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

CONDITION	Past	Currently Has
Heart Defect/Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding/Clotting Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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, Continued

2. Complete the following:

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

If yes, please explain: _____

b. Is participant able to swim? YES NO Circle level of ability: beginner intermediate advanced

c. Does participant have a current tetanus shot? YES NO Date of shot: __/__/__

d. List current medications (please send with directions to be administered during trip):

e. I give permission for me/my child to be administered the following as needed for minor discomfort while on the educational field trip: (check all that apply)

- Tylenol Advil/Motrin Cough drops over-the-counter allergy meds
 Antacid Other: _____

f. 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:

Read and sign the following:

This health history provided in this document is correct so far as I know. I understand that participation in this trip and activities is entirely voluntary. I understand that the trip **may involve**: a lot of walking, swimming, possibly being outdoors in bad weather and riding on a bus for extended periods of time. I know and understand the risks and dangers involved in the above-named activities and I know and understand that unanticipated dangers might arise. Trip chaperones will do everything possible to minimize potential hazard or risk.

Parent/guardian signature or adult participant signature

Date