MEDICAL INFORMATION

Go Palestine

To be Completed by a Parent or Guardian of the Trip Participant

PLEASE COMPLETE, SIGN, SCAN & RETURN AS SOON AS POSSIBLE TO: gopalestine@rfs.edu.ps

Note: The following medical and contact information may be necessary in the unlikely event of illness or accident. The facts you disclose will be kept confidential and will only be used by The Ramallah Friends School office and the program staff to respond to an injury or illness. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness.

PART I: CONTACT INFORMATION

Participant's Name: _____

Date of Birth: _____ **Gender:** _____

Address: _____ **City:** _____ **State/Province:**_____

Country: _____**Zip or other code:** _____ **Home Phone #** _____

Person(s) we should contact FIRST in case of an emergency: _____

Name of Custodial Parent: _____ (check one): **Mother Father Guardian**

Work Phone#_____**Cell Phone#**_____

Second Parent: _____ (check one): **Mother Father Guardian**

Work Phone # _____ **Cell Phone #** _____

Alternate Emergency Contact Person: _____

Relationship to Participant: _____

Phone# _____ **Alt. Phone #** _____

Address _____ **City, State, Zip** _____

PART II: INSURANCE AND PROFESSIONAL INFORMATION

Please indicate your hospitalization information for emergency use.

Is the participant covered by travel medical/hospital insurance? NO YES

If yes, please indicate the following information:

Insurance carrier or plan name: _____ **Policy#:** _____

Group Policy #: _____

Address of Carrier: _____

Name of family physician:_____ **Phone#** _____

Name of family dentist:_____ **Phone #** _____

PART III: PARTICIPANT MEDICAL HISTORY

1A. Is your son/daughter currently taking any medications on a regular basis?

__NO

__YES: If so, please list ALL medications (including over the counter or nonprescription drugs) your child has taken routinely in the past 3 months. (Please attach any additional information).

Medication	**Taken For** (Condition/Symptom)	**Dosage** (Size/Frequency)	**Date Started**	**Current Side Effects** (If any)

1B. If your son/daughter is currently taking routine medications? Do you plan to have your son/daughter continue to take these medications during the program? ___ YES ___ NO (if no, please explain below)

1C. If your son/daughter is planning on taking routine medications during the program, who will be responsible for handling and administering the medications:

_____ My child will be responsible for administering his/her own medication(s) &/or vitamins
_____ I prefer the Go Palestine staff to hold onto my son/daughter's medications and disperse them as prescribed.

2. Does your son/daughter have any known allergies (including medication allergies, food allergies, or other)?
__NO __YES

Type	Describe reaction and appropriate management of reaction (please use addition sheet if necessary)

3. Has your son/daughter ever been diagnosed with any mental health conditions?
___ NO
___ YES If yes, please describe separately if space is needed.

4. Does your son/daughter have any dietary restrictions we should know about?

6. Has your son/daughter ever had any history of the following? (Please check corresponding circle if there is a history.)

__ Allergies
__ Asthma
__ Frequent headaches
__ Ear infections
__ Cramps
__ Diarrhea/
__ Constipation
__ Epilepsy
__ Recent injuries of any kind
__ Surgery
__ Mononucleosis
__ Myocarditis
__ High Blood Pressure
__ Pneumonia
__ Back Problems
__ Neck Problems
__ Shoulder Problems
__ Knee Problems
__ Foot Problems
__ Chronic Pain
__ Diabetes
__ Dizziness
__ Infectious Disease
__ Fainting
__ Recurrent
__ Dental Problems
__ Lyme's Disease
__ Mental Illness
__ Gastrointestinal Problem
__ Heart Problems
__ Hepatitis
__ Phobias (claustrophobia, etc.)
__ Eating Disorders:
__ Anorexia Nervosa
__ Bulimia
__ Emotional difficulties for which professional help was sought
__ Wears glasses, contacts, or protective eye wear
__ COVID-19

Please explain any checked item(s) on a separate piece of paper if necessary.

PART IV: PARENTAL CONSENT *Important- this authorization must be complete for enrollment in program.

PARENT/GUARDIAN AUTHORIZATION:
This health history is correct and complete as far as I know. The participant herein described has permission to engage in all program activities except as noted. I hereby give permission to Ramallah Friends School to provide routine health care, administer prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.
It is understood that in case of emergency, Ramallah Friends School will make every reasonable attempt to immediately contact this participant's parent(s) or guardian(s). In the event I cannot be reached in an emergency, I hereby give permission to the licensed physician selected by Ramallah Friends School to secure and administer treatment, including hospitalization, injections, anesthesia or surgery, for my child. This completed form may be photocopied for use of staff in the field.

Parent /Guardian signature _____ Date_____

Printed name _____ Additional notes attached ____Yes ___ No