Trip Medical Information--Please be specific.
(To be kept with trip leader.)

Registrant's Name ____

Name of Nearest Relative ________________________ Phone (_____)__________________

Is the participant his or her own Guardian? ___Yes__No Cell number(_____)______________

If "No," then who? ________________________

Relationship to participant____________________ Phone (_____)__________________

Group Home Name ____________________________

GH Contact Name ________________________ Phone (_____)__________________

Emergency Name ____________________________ Phone (_____)__________________

Are you going on vacation while your child/sibling/ward is on this trip? ____ Yes ___ No

If marked "Yes," indicate a phone number where you can be reached. Phone (_____)____________

Primary Doctor ______________________________ Phone (_____)__________________

Medical Insurance Policy: Company name ____________________Policy # __________

ALLERGIES

Does the participant have any know allergies? ______ Yes ______ No

Please check all that apply: ______ Animals ______ Bee Stings ______ Bug Bites

______ Chlorine ______ Dust ______ Hay Fever ______ Pollen

______ Medications ____

______ Other ____

BEHAVIOR MANAGEMENT

Does the participant act out? ______ Yes ______ No Please explain: ______________________

____

What type of behavior management/calming techniques work best? ___________________________

____

Is there anything specific that will upset the participant? ____________________________________

____

M-NASR reserves the right to deny a participant the privilege to participate in the next trip if behavior is unacceptable. Please read the "Behavior Code of Conduct" in the Brochure.

DIETARY NEEDS

Does the participant have a special diet or dietary restrictions?______ Yes ______ No

Please explain: ____

Does the participant need assistance eating? ______ Yes ______ No Explain:______

Do you usually eat (check if "**Yes**"): _____ Breakfast _____ Lunch ____ Dinner

OTHER INFORMATION

What time does the participant usually go to bed?__________ Get up in the morning? __________

How long does it take the participant to get ready? ______________

How much supervision does the participant need during activities? ____________________

SEIZURE

Is the participant subject to seizures? ______ Yes ______ No

Noticeable signs of oncoming seizures: ____

How long do the seizures usually last? ____

MEDICAL

Please circle medical conditions: PKU/Atlanto Axial Instability/Shunt /Catheter /Colostomy Bag

Assistive Devices used: _____Glasses/Contacts ___ Hearing Aid ______ Prosthesis

_____Other ____

Any major accidents/injuries or hospitalizations in the past year? ___ Yes ______ No

Please explain if "Yes" and Doctor's restrictions: ____

____

Does the participant have any phobias/fears (i.e., fear of dogs, heights, water, confinement, etc.)

______ Yes ______ No Please describe ____________________________________

Are there any other physical or medical conditions that the staff should know about? Please explain

____

Will the participant be taking medication while on this trip? ______ Yes ______ No

Does the participant self-medicate? ______ Yes ______ No

Please list below any medication the participant is currently taking.

NAME OF MEDICATION DOSAGE SIDE EFFECTS

NAME OF MEDICATION	DOSAGE	SIDE EFFECTS

Does M-NASR staff have permission to distribute:

Pain reliever? ______ Yes ______ No Type ________________________________

Motion-sickness medication? ______ Yes ______ No

____ ________________________

Legal Guardian's Signature **Date**