

# National Hispanic Environmental Council



## STUDENT MEDICAL FORM

### THE 2<sup>nd</sup> ANNUAL NEW YORK CITY MINORITY YOUTH ENVIRONMENTAL TRAINING INSTITUTE

**“6 Days of Learning, A Lifetime of Experience”**

**June 28–July 3, 2007 • New York, NY**

(You must fill out this Form completely)

Please fill out this form and include it with your Application package. You must submit the Medical Form for your application to be considered. **You must fill out the Form completely, if you leave out any information, your application will not be considered.** Use additional paper as necessary.

NHEC needs this information so that Institute staff will know – in advance — of any special medical conditions you may have, rather than learning about them during the Institute, should a medical emergency arise. Also, in the event of injury or illness, this Form provides medical personnel with key information regarding your medical history. Because of this, it is vital that you be as complete, accurate, and truthful as possible. This Form is not used to screen out applicants.

## GENERAL INFORMATION

Your Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-Mail (student's and parents, if available):

Student's: \_\_\_\_\_ Parents: \_\_\_\_\_

How old are you now? (Example: 16, 17, etc.): \_\_\_\_\_

- over -

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Birthdate: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Social Security Number: \_\_\_\_\_

**Person to Notify in Case of Medical Emergency:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Day/Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

**If the Above Person is Unavailable, please notify:**

Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Day/Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

**MEDICAL INSURANCE INFORMATION**

We strongly encourage you to have medical insurance and to bring your insurance card or other documentation with you to the Institute.

Insurance Carrier: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Contact Phone Number (if applicable): \_\_\_\_\_

**VITALS** (You must provide all information—fill out every line—We mean it!)

Your date of birth: \_\_\_\_\_ Resting Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

**EYES**

Any problems with your eyes or vision? \_\_\_\_\_

Do you wear glasses or contacts? \_\_\_\_\_

(If so, we strongly recommend bringing an extra set of glasses or contacts to the Institute.)

**ALLERGIES**

Have you ever had a reaction to any medication, including aspirin? \_\_\_\_\_

If so, how severe are your reactions? Please explain: \_\_\_\_\_

\_\_\_\_\_

(please use a separate sheet of paper, if necessary)

Are you allergic to anything? \_\_\_\_\_ Please list: \_\_\_\_\_

(please a separate sheet of paper, if necessary)

In particular, are you allergic to bee stings? \_\_\_\_\_

If so, how severe are your reactions? Please explain: \_\_\_\_\_

Do you carry an anaphylaxis kit? \_\_\_\_\_

### **ILLNESSES AND MEDICATIONS**

List any recent illnesses: \_\_\_\_\_

List any accidents, operations, or hospitalizations and dates occurred: \_\_\_\_\_

List any exposure to infectious diseases and dates occurred: \_\_\_\_\_

Have you ever experienced any conditions or illness related to altitude? \_\_\_\_\_

If so, please explain, and tell us when: \_\_\_\_\_

Please describe any medications you are taking, why you are taking them, how much and how often: \_\_\_\_\_

**Note: Participation in the Institute will require some physical exertion, including hiking, walking, and other physically and mentally demanding efforts.** Several times during the Institute, the coursework will take students to somewhat isolated areas without immediate access to medical facilities or medical staff. Given the above, please list all physical or mental limitations and/or restrictions of which you are aware: \_\_\_\_\_

**Important: If you have no limitations or restrictions, please sign here:** \_\_\_\_\_

### **TETANUS:**

The danger of tetanus in natural areas can sometimes be severe. You must be inoculated against this fatal disease and you need a booster every ten (10) years.

Give the date of your most recent tetanus inoculation or booster: \_\_\_\_\_

**PHYSICAL EXAMINATION**

A recent physical examination is recommended and may be required by NHEC.

Date of most recent physical: \_\_\_\_\_

Doctor's name: \_\_\_\_\_

Address: \_\_\_\_\_ City, State: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**APPLICANTS SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PARENT OR LEGAL GUARDIAN SIGNATURE:** \_\_\_\_\_

**(required for all Applicants, even if you are over 18) DATE:** \_\_\_\_\_

**(PARENTS—you must sign your name clearly)**

**REMEMBER: Be sure to include this form with your application.**