

Additional Health Information & Epi-Pen Form

Participant Name: _____

Health Insurance Provider: _____ Plan or Group # _____

Participant's Physician: _____ Phone: _____

Medical Conditions/Behavioral Issues

Does the Participant suffer from Asthma? Yes _____ No _____

If yes, is the Participant's asthma exercise induced? Yes _____ No _____

Does the Participant carry a rescue inhaler? Yes _____ No _____

Has the Participant been diagnosed with Hypertension? Yes _____ No _____

Has the Participant been diagnosed with Diabetes? Yes _____ No _____

Has the Participant been diagnosed with Epilepsy/Seizures? Yes _____ No _____

Has the Participant been diagnosed with Heart Disease? Yes _____ No _____

Does the Participant wear prescription eye glasses or contacts? Yes _____ No _____

Does the Participant have any behavioral issues? Yes _____ No _____

If yes, describe the behavioral issue, triggers, and suggestions for assisting Participant: _____

Has the Participant been diagnosed with any other medical conditions not listed above? Yes _____ No _____

If yes, describe the medical conditions: _____

Please list any medication the Participant is currently taking and why: _____

(Attach Additional Sheet if Necessary)

Allergies

Does the Participant have any life threatening allergies? (food, medication, plants, animals, insects, etc.) Yes _____ No _____

Participant's anaphylaxis triggers are:

_____ Peanuts _____ Nuts _____ All Dairy _____ Eggs _____ Shellfish _____ Fish

_____ Food Additives, list: _____

_____ Insects/Bites, list: _____

_____ Medications, list: _____

_____ Other, list: _____

Participant's anaphylaxis symptoms usually are:

_____ Swelling (eyes, lips, face, tongue) _____ Coughing/Choking _____ Difficulty Breathing/Swallowing _____ Vomiting

_____ Stomach Cramps/Diarrhea _____ Flushed Face/Body _____ Dizziness/Confusion _____ Change of Voice

_____ Fainting/Loss of Consciousness _____ Cold, Clammy, Sweaty Skin _____ Other, list _____

Participant's emergency treatment is:

_____ Anti-Histamine (list precise measuring instrument, specific brand, and dosage): _____

_____ Epi-Pen _____ Other, list: _____

EPI-PEN REQUIREMENTS:

(initial after each of the below listed requirements)

- Participant must provide the program with two, non-expired Epi-Pens (initials) _____
- Epi-Pens must be in original container with appropriate label intact (initials) _____
- Participant must be trained to administer an Epi-Pen without assistance (initials) _____

Epi-Pens Expiration Dates: ____ / ____ / ____ ____ / ____ / ____

Number of times the Participant has used an Epi-Pen: _____ Date of last use: ____ / ____ / ____

In the Event of an Anaphylactic Reaction:

1. Staff/Program Instructors may provide assistance to the Participant as he/she injects him/herself. Note: Staff/Program Instructors are not trained medical professionals, but have completed the Standard First Aid Training and will assist to the best of their ability.
2. Staff/Program Instructors will call 9-1-1 immediately to have an ambulance come to the program/event site.
3. Staff/Program Instructors will call parent/legal guardian/emergency contact to inform them of the incident and to inform them the Participant is being transported by emergency personnel to the hospital.

Epi-Pen Waiver

(Only if Participant requires an Epi-Pen on-site)

I release Lake Havasu City, and its officers, directors, employees, independent contractors, and volunteers from any and all liability arising out of or in connection with the decision to administer or not administer or to assist with the administration of epinephrine.

I agree to indemnify and hold harmless Lake Havasu City, and its officers, directors, employees, independent contractors, and volunteers of and against any and all liability, damage, claim, demand, cost, and expense (including without limitation of attorney’s fees) arising out of or in connection with the use or non-use of an Epi-Pen for Participant and any action, claim, or other legal proceeding brought against Lake Havasu City by a parent/legal guardian/spouse/family member who has not signed in agreement.

Participant/Parent/Legal Guardian Signature: _____

If Parent or Legal Guardian Printed Name: _____