*Note: **ADULT PROGRAM ATTENDEES** — this form **IS NOT** required. Advanced Adult Program attendees must complete the UAT SCUBA form.*

Health Form

FAX: (256) 890-3370

U.S. Space & Rocket Center®
Attn: Shannon Sanford
P.O. Box 070015
Huntsville, AL 35807

A physician or nurse practitioner signature is required on your health form. Trainee cannot begin the program unless all forms are completed and required signatures are provided. Please return completed form in the enclosed self-addressed envelope NO LATER THAN FOUR WEEKS PRIOR TO CAMP SESSION DATE or your reservation is not complete and may be cancelled. Be sure to keep a copy for your files.

■ TRAINEE INFORMATION *(PLEASE PRINT)*

Trainee: ______________________________
Last First Name MI

Group Name (IF APPLICABLE) ______________________________

Camp Account # ______________________________

Session Date: ______________________________

Age at time of camp: ____ Date of Birth ___/___/___ Sex: ____

Parent's Name: ______________________________
Last First Name MI

Address: ______________________________

City: ______________________________

State: ______________________ Zip: __________

Daytime Telephone: (   ) ______________________

Evening Telephone: (   ) ______________________

Cell Phone Number: (   ) ______________________

Emergency Contact: ________ Other than parents ________

Relationship to Trainee: ______________________

Telephone: (   ) ______________________

Is trainee covered by health insurance: ☐ Yes ☐ No

Please attach copy of both sides of insurance card or claim form. List all medical conditions, physical or learning disabilities; and any emotional or behavioral problems. (Attach behavioral plan.)

____

____

Drug Allergies: ______________________________

____

Food Allergies: ______________________________

____

Diet Restrictions: ______________________________

____

Are immunizations up-to-date? ☐ Yes ☐ No
If no, please attach an exemption form or explanation.
Date of last tetanus booster: ______________________
Prescription medications trainee will require while at camp:

______________ ______________

______________ ______________

Authorized persons for the trainee to be released to in the event of an emergency or at the conclusion of the program:

1. ______________________ ______________
NAME RELATIONSHIP

2. ______________________ ______________
NAME RELATIONSHIP

ALL prescriptions, over-the-counter medications, vitamins, and herbal products are collected and administered by nursing staff and MUST be in original containers with labels and dispensing instructions in English. Individuals requiring injections should provide medications, syringes and written instructions signed by physician.

Trainees maintain a vigorous pace from 7 a.m. to 9-10 p.m. During simulator training, individuals may experience up to three G's of gravitational force, strobe or flashing lights or fluid shifts. Persons with cardiac conditions, severe pulmonary dysfunctions, sensory handicaps or chronic illness may not be able to participate fully in the program. We require that trainee has received a physician's examination within two years prior to attending scheduled program. Any recent illnesses must be noted and trainee **MUST** have physician's or nurse practioner's clearance to attend.

■ PHYSICIAN'S MEDICAL STATEMENT

A physician or nurse practitioner signature is mandatory for all camps and trainee cannot participate in all activities without it.

I have examined ______________________________
Trainee

on ______________________ . The trainee is in good health
Date

and is physically and mentally able to participate in this program. The trainee does not have any injury, illness or disability that will prohibit activity.

X ______________________________

Physician/Nurse Practitioner signature Date

■ AUTHORIZATION FOR MEDICAL TREATMENT

MUST BE SIGNED BY PARENT/GUARDIAN

______________________________ has my permission
Trainee

to take any over-the-counter medications (listed below) as needed with the exception of ______________________
______________________ while attending this program.
I verify that you have my permission to take
______________________________ to the nearest
Trainee

medical facility for emergency treatment and I assume responsibility for payment.

X ______________________________

Parent/Guardian or Adult Trainee Signature Date

The following generic medications are stocked in the clinic and dispensed free of charge as needed: acetaminophen, ibuprofen, decongestant, antihistamine, cough suppressant, throat lozenges, motion sickness medication, anti-nausea, anti-diarrheal, milk of magnesia, antibiotic ointment, anti-itch cream, ipecac, topical oral pain reliever.

Should your child require medical attention, you may ask us not to use or disclose any part of your protected health information for the purposes of treatment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved. Your request must state the specific restrictions requested and to whom you want the restrictions to apply. Medical-related questions may be directed to the Nursing Staff at (256)721-7162.

Name: ______________

CAMP Account # ______________

Session Date ______________