Haiti Plunge Inc. email: thehaitiplunge@gmail.com www.thehaitiplunge.org
FB The Haiti Plunge Tele: (413) 346-3241

Residence
21 Maple Street
Adams, MA 01220

Mailing Address
P.O. Box 376
Adams, MA 01220

2019 MEDICAL FORM

Note to parents/guardian: The Haiti Plunge wants its mission program to be safe and healthy. However, in the event of an accident or illness it is important that we have the following Information in hand:

1. **Medical history**
2. **Proof of physical examination within the past year.**
3. **Medical insurance information**

PLEASE PRINT CAREFULLY

Cell #
_________________________________ DOB___ /____/____Age___ Gender____ ( )____________
First Last

Parent/Guardian Name _________________________________ Cell phone ( ) _____________

Home Address _________________________________Home phone ( )_____________
Street City State Zip

Name of Business_________________ _________________Phone ( )______________

Work Address____
Street City State Zip

Second Parent/guardian contact_________________________________ Phone ( ) ______________
Last name First

HEALTH HISTORY (Give approximate dates)	DISEASE (dates)	ALLERGIES (Check all that apply)
_____Frequent Ear Infections	______Chicken Pox	______Hay Fever
_____Heart Defect/Disease	______Measles	______Poison Ivy
_____Diabetes	______German Measles	______Insect Stings
_____Bleeding/Clotting Disorder	______Mumps	______Penicillin
_____Hypertension	______Hepatitis A	______Other Drugs
_____Mononucleosis	______Hepatitis B	______Food (specify)
_____Convulsions	______Hepatits C	______________________
_____Epilepsy		______Other (specify)

PLEASE PROVIDE DATES WHERE APPROPRIATE

Operations or serious injuries____

Chronic illness or medical condition____

Dietary Restrictions____

Current Medications (send with instructions)_________________________________

Other disease or medical condition____

Family Physician_________________________________**Phone ( )** ______________

Family Dentist__________________________________**Phone ( )**______________

IMMUNIZATION HISTORY (Month and year of immunization and recent booster) Record from a physician may Be attached.

Vaccine Type ________ First immunization ________ Booster ________

DPT: Diphtheria, Pertussis, Tetanus ________

TD: Tetanus, Diphtheria ________

Oral Polio: (TOPV) ________

Injectable Polio (SALK) ________

MMR: Measles, Mumps, Rubeola ________

Tuberculin Test: ________

HIB: Haemophilus Influenza B ________

Hepatitis A: ________

Hepatitis B: ________

Hepatitis C: ________

Participants for the Haiti Plunge must have a physical within a 12 month period. A copy of that physical must be Attached to this form. The physician must have a signature on the form with the date of your physical.

Name of insurance company: ________ -Policy Number ________

Insurance company address ________ Tele. No. ________

If I am under age 18, my parent or guardian, by signing below, also consents to my release and he or she agrees that this release shall be binding upon him or her as my estate, heirs, personal representatives and assigns. My parent or guardian also promises, by signing below to defend, indemnify and hold the HAITI PLUNGE, INC. Harmless from any claim asserted by me against the Haiti Plunge, Inc. including its directors, employees and agents. If I should repudiate this release after obtaining adulthood.

I hereby grant permission to the Haiti Plunge, Inc. the right to use, reproduce, and/to distribute photographs, films, video-tapes, and sound recordings of my child or myself without compensation or approval rights, for use in materials created for purposes of promoting the activities of the Haiti Plunge.

Signature of parent/guardian/adult participant________ Date:________

Signature of minor ________ Date:________

BE SURE ALL SIGNATURES ARE ON THIS FORM

***** ATTACH IMMUNIZATION RECORDS TO THIS FORM**