BOZEMAN
FIELD SCHOOL

Medical History & Authorization to Treat

Part 1: Basic Medical History
To be completed by Parent(s)

Today's Date: _____ For School Year: _____ New or Returning Student (circle) _____

Student Information:
Name: _____ DOB: _____ Sex: _____
Height: _____ Weight: _____ Shoe size: _____

Parent/Guardian 1:
Name: _____ Relationship to Student: _____
Day Phone: _____ Night Phone: _____ Cellphone: _____
Email: _____
Address: _____

Parent/Guardian 2:
Name: _____ Relationship to Student: _____
Day Phone: _____ Night Phone: _____ Cellphone: _____
Email: _____
Address: _____

Relationship between Parent/Guardian 1 and 2: _____
Other information relevant to family situation: _____

Additional Emergency Contact:
Name: _____ Relationship to Student: _____
Day Phone: _____ Night Phone: _____ Cellphone: _____
Email: _____
Address: _____

Part 2: Medical Insurance & Provider Information
Primary Care Provider: _____
Phone: _____ Address: _____

If the student regularly sees a specialist for a condition that may affect their participation at school, please provide contact information below (attach additional sheets as needed).

Provider: _____ Specialty: _____
Phone: _____ Address: _____

Health Insurance Provider: _____
Name of Insured: _____
Plan ID: _____ Group ID: _____

Please provide a photocopy or scan of both sides of the student's insurance ID card.

Part 3: Health History

Condition or History	Yes	No	N/A
Addiction and/or regular use of alcohol, drugs, or tobacco/nicotine	☐	☐	☐
Altitude illness (AMS, HAPE, HACE)	☐	☐	☐
Asperger's, Autism, or PDD	☐	☐	☐
Autoimmune disorder	☐	☐	☐
Bleeding, Blood Disorders, Tuberculosis, Hepatitis	☐	☐	☐
Cancer	☐	☐	☐
Cardiovascular abnormalities/problems	☐	☐	☐
Circulatory problems	☐	☐	☐
Cold injuries (frostbite, hypothermia, Reynaud's)	☐	☐	☐
Dental problems	☐	☐	☐
Diabetes	☐	☐	☐
Ear, Eye, Nose & Throat Infections/Issues/Problems	☐	☐	☐
Eating Disorder (anorexia, bulimia, etc.)	☐	☐	☐
Epilepsy (or other seizure disorder)	☐	☐	☐
Fainting or Dizziness	☐	☐	☐
Gastrointestinal abnormalities/problems (inc. ulcers, Crohn's, celiac, etc.)	☐	☐	☐
Head injuries/conditions (inc. concussions, TBI, migraines, etc.)	☐	☐	☐
Heat injuries/illness (heatstroke, etc.)	☐	☐	☐
Hormonal & Thyroid conditions	☐	☐	☐
Hypertension	☐	☐	☐
Kidney or Liver Disease or Issues	☐	☐	☐
Menstrual Cramps and/or abnormal cycle	☐	☐	☐
Neurological disorders	☐	☐	☐
Pregnancy (current)	☐	☐	☐
Reproductive and/or urinary tract problems	☐	☐	☐
Respiratory issues (inc. asthma)	☐	☐	☐
Skin problems/issues	☐	☐	☐
Sleep disorder (inc. sleepwalking, apnea, incontinence)	☐	☐	☐
Sudden death under age 50 of family member	☐	☐	☐
Surgery requiring anesthesia in the past 5 years	☐	☐	☐

Condition or History	Yes	No	N/A
Syncope with exertion (fainting during exercise)	☐	☐	☐
Vision or hearing loss or impairment	☐	☐	☐
Other (including any hospitalization in the past 5 years)	☐	☐	☐

If you responded **yes** to any of the above questions, please provide details here, adding additional pages as needed:_____

Has the student been diagnosed with (or is suspected of having) a learning disability or other significant learning challenge (ADHD, dyslexia, dysgraphia, executive function, dyscalculia, autism spectrum etc.)?

Yes ☐ No ☐ *If yes, please fill out the **Learning Difference Addendum***

Does the student have any dietary restrictions?

Yes ☐ No ☐ *If yes, please fill out the **Dietary Restriction Addendum***

Does the student have any known allergies (Bee/insect stings, shellfish, iodine, nuts, dairy, other foods, pollen, medications, or any other known allergens)?

Yes ☐ No ☐ *If yes, please fill out the **Allergy Addendum***

Has the student had any significant orthopedic injuries (shoulder, arm, elbow, hand, neck, back, hips, leg, knee, ankle, foot, recurrent strains of particular muscles, recurrent sprains, hernia, other musculoskeletal issues, or other athletic or orthopedic injuries)?

Yes ☐ No ☐ *If yes, please fill out the **Orthopedic Addendum***

Does the student regularly take any medications (including prescription medications, over-the-counter medications, dietary supplements, herbal remedies, and any other medications)?

Yes ☐ No ☐ *If yes, please fill out the **Medication Addendum***

Has the student been under the care of a mental health care professional (counselor, psychologist, therapist, etc) in the past two years, or does the student have a history of depression, anxiety, self-harm, addiction, suicidal ideation or attempt, or any other mental health issue, illness, disorder, or abnormality?

Yes ☐ No ☐ *If yes, please fill out the **Mental Health Addendum***

Part 4: Acknowledgement, Agreement, and Authorization

ACKNOWLEDGEMENT/AGREEMENT:
To the best of my knowledge, this medical form and any supplemental medical information I submit (any supplemental information incorporated by this reference) contains accurate and complete information. I understand the nature of BFS activities, and acknowledge that I can contact BFS should I have any questions about these activities or the associated physical, mental or emotional demands or other concerns. Other than any limitations described in this form (or in information submitted by the student's health care provider/s), the student agrees, and has permission from his or her parent/s if he or she is a minor, to participate in all BFS activities. I agree to contact BFS if any medical or health condition changes before the start of the BFS program. I understand that falsifying or providing inaccurate or incomplete medical or health information can create serious risks to the student and others, and/or can result in the student's dismissal from the program. I understand the student's final acceptance and participation in the program is contingent upon BFS representatives' review of all forms, including this one. I understand that although BFS will review this information and may allow participation, BFS cannot anticipate or eliminate risks or complications posed by a student's mental, physical, or emotional condition. I understand that emergency, medical, drug and/or health issues, response, assessment or treatment are included within the scope of – and expressly subject to the terms of – the BFS Acknowledgment and Assumption or Risks & Release and Indemnity Agreement. I certify that I have reviewed that Document carefully in regard to the activities, risks and responsibilities associated with participation in BFS programs.

I consent here to allow BFS staff or its consulting health care providers to contact and communicate with the student's health care provider/s listed in these forms about the student's health and medical condition or care. BFS keeps and provides regular over-the-counter medications for minor illness (headaches, cramps, cold & flu, sore throat, etc.) and asks that students do not bring them. Signing this Acknowledgement/Agreement gives BFS permission to administer over- the-counter medications.

MEDICAL AUTHORIZATION:
I authorize Bozeman Field School (BFS) staff, representatives, contractors, and/or other medical personnel to obtain or provide medical care for me/my child, to transport me/my child to a medical facility, and/or to provide treatment (including, but not limited to hospitalization, medications, injections, anesthesia, or surgery) they consider necessary for my/my child's health. I agree to the release (to or by BFS) of any records necessary for treatment, referral, billing, or insurance purposes. I agree that BFS has no responsibility for medical care provided to me/my child, and agree to pay all costs associated with this care, including but not limited to medical evacuation, travel, compensation and expenses for staff accompanying the student, medicine and treatment. This form may be photocopied for use in the field.

Participant and one parent of a minor participant, or both parent/s, if available, must sign below:

_____	_____	_____
Participant Name (printed)	Date	Participant Signature
_____	_____	_____
Parent/Guardian 1 Name (printed)	Date	Parent/Guardian 1 Signature
_____	_____	_____
Parent/Guardian 2 Name (printed)	Date	Parent/Guardian 2 Signature