Stephenson Hall, Second Floor
CPO 2170, Berea, KY 40404
895.985.3805
www.berea.edu/celts

Child Health Form

The information on this form is not part of the program acceptance process, but is gathered to assist us in identifying appropriate care should the need arise. Any changes to this information provided on this form must be provided to program personnel immediately. Provide complete information so that staff will be aware of your child's needs. We will make every effort to reach responsible parties, should the need arise, in the order listed below.

Participant's Name _____ Birth Date _____

Home Address_____

School_____ Grade_____Gender_____

Custodial parent/legal guardian _____

Home Address_____Phone: _____
(If different from above)

Additional Phone(s): _____

Second parent or legal guardian or emergency contact_____

Address_____Phone:_____

Additional emergency contact_____

Relationship _____

Address _____Phone: _____

Insurance Information

Is the participant covered by family medical insurance? ☐ Yes ☐ No

If so, indicate carrier or plan name _____ Group # _____

Name of insured _____ Relationship to participant _____

Allergies List all known. Describe reaction and management of the reaction

Medication allergies (list)

_____ _____

_____ _____

Food allergies (list) **PLEASE NOTE WELL: While CELTS will not serve items on this list to your child we are NOT able to guarantee an allergen free zone in any of our program spaces (including the dining hall, Seabury Gym, and other campus locations we use).**

_____ _____

_____ _____

Other allergies (list) – include insect stings, hay fever, asthma, animal dander, etc.

_____ _____

_____ _____

Medications being taken

Please list ALL medications (including over-the-counter or nonprescription drugs) taken routinely. Any medications that must be taken during program time should remain in the original packaging/bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage, and the frequency of administration.

☐ This person **takes NO medications** on a routine basis OR

☐ This person **takes medications** during program times as follows:

Med. #1 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Med. #2 _____ Dosage _____ Specific times taken each day _____

Reason for taking _____

Attach additional pages for more medications.

RESTRICTIONS (The following restrictions apply to this individual.)

Does not eat: ☐ Red meat

☐ Pork

☐ Dairy Products

☐ Poultry

☐ Seafood

☐ Eggs

☐ Food Dye

☐ Peanut Butter

☐ Gluten

☐ Sugar (those sugars not found in natural settings like fruits)

☐ Other _____

Explain any restrictions to activity (e.g. activities in which the child cannot participate).

Use this space to provide additional information about the participant's behavior and physical, emotional, or mental health about which our programs' staff should be aware.

Name of family physician _____

Address _____

Phone _____

In all emergencies when prior authorization cannot be obtained from me or the other emergency contacts specified above, I authorize Berea College's CELTS program staff to secure emergency medical treatment on my child's behalf, including surgery and the administration of an anesthetic. I accept all financial responsibility for such treatment and expenses. I agree to release, indemnify and hold harmless Berea College, its trustees, officers, employees, students and agents, including staff of CELTS, in connection with any treatment rendered pursuant to the permission given in this document.

This form may be photocopied for trips off Berea College premises.

Information on this form may be shared with Berea College staff and students involved with CELTS programs.

Signed _____ Date _____
(Parent or Legal Guardian Signature)

Printed Name _____