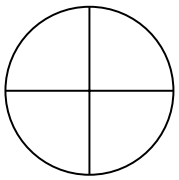
Earth Arts HEALTH & EMERGENCY CONTACT FORM



Participant's Name_____
Address_____
City_____
State____ Zip_____- _____
Age_____ D.O.B. _____
Identifies as a Male____ Female____
E-Mail _____
Home Phone ( ) _____ - _____
Cell / Other ( ) _____ -_____

NOTE: If you have a physical/mental condition that Earth Arts Programs should be aware of, it is your responsibility to let us know of the existing condition prior to start of any program. The information will be held in confidence and used only to render assistance should the need arise.

PARENT OR GUARDIAN
(Only if participant is under 18 years old)
Name_____
Address_____
City_____
State____ Zip_____- _____
E-Mail _____
Home Phone ( ) _____ - _____
Cell / Other ( ) _____ -_____

EMERGENCY CONTACT PERSON
(All participants must complete)
Name _____
Address _____
City _____ St: ___ Zip: _____
Emergency Contact Phone ( ) _____- _____
2nd Emergency Contact Name & Phone ( )_____
_____

1. Do you wear contact lenses? _____ or a hearing aid? _____
2. Date of last Tetanus Booster: _____
3. Do you have asthma of any sort? _____ If yes, describe_____
4. Do you have any physical disabilities or limitations, such as past or current injuries, that we should be aware of? Please be specific:_____

5. Are you currently on any medication? _____
If yes, indicate specific medication(s) _____
_____
6. Are you allergic to any of the following:
Medication (e.g. penicillin, aspirin) Yes No
Insect Bites (e.g. wasps, bees, spiders) Yes No
Foods (e.g. peanuts, shellfish) Yes No
Plants (e.g. poison ivy, nettles) Yes No
Please list any other allergies: _____
Describe details for any checked "yes": _____
_____
7. Have you ever had frostbite? _____ If so, to which part of your body? _____
8. Is there any other condition that we should be aware of that may endanger, alter, or somehow limit your abilities to participate in any Earth Arts Programs?_____
_____
9. Name of Health Insurance Carrier: _____ Group Plan Number: _____
10. Name of Physician_____ Physician Phone: ( ) _____ - _____

Provided parents or emergency contacts cannot be reached within reasonable time, I hereby voluntarily consent to the rendering of such care, including diagnostic procedures, surgical and medical treatment, by authorized members of the hospital staff or their designees, as may in their professional judgment be necessary. I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on child's condition. I acknowledge that I am responsible for all charges in connection with care and treatment rendered during this period.

_____ _____ _____
PARTICIPANT OR PARENT/GUARDIAN SIGNATURE **PRINT NAME** **DATE**

Please complete, sign, & return to: Earth Arts, PO Box 596, Ithaca, NY, 14851