Rotary | GREAT PLAINS RYLA
District 5630/District 5610

Personal Medical Record

This form must be completed and returned by June 1, 2023. A licensed medical provider must complete Physical Examination form on page 5.

Please type the following if at all possible, or print very neatly:

First Name _____ **Middle Initial** _____ **Last** _____

Date of Birth _____/_____/_____ ☐ **Male** ☐ **Female**

Address _____ **City** _____ **State** _____ **Zip** _____

In case of emergency, notify:

Name _____ **Relationship** _____

Home Phone (_____) _____-_____ **Business Phone** (___) _____-_____ **Cell Phone** (_____) _____-_____

Health/Accident Insurance Company: _____ **Policy No.:**

Please attach a photocopy of both sides of your insurance card. If you do not have medical insurance, please enter "none" in the Health/Accident Insurance Company line above.

Medication

List all medications currently used, including any over-the-counter medications. If no medication, indicate "none."

Medication	Dose	Frequency	Reason

☐ **I authorize RYLA staff to provide my child with non-prescription medication with these exceptions:**

_____

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

Great Plains RYLA Medical Record - Due by June 1
Please mail or drop off to your local Rotary Club RYLA Representative.
Contact information can be found at
www.greatplainsryla.org/contact/rylarepresentatives-2

Immunizations

The following immunizations are recommended by Great Plains RYLA. Tetanus immunization is required and must have been received within the last 10 years. For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY).

Immunized?		Immunization	Date (MM/YY) *(Must provide dates)*	Had Disease?		Date (MM/YY)
Yes	No			Yes	No	
	Exemption to immunizations claimed (exemption form required in this medical form required)					
		Tetanus				
		Pertussis				
		Diphtheria				
		Measles/mumps/rubella				
		Polio				
		Chicken pox				
		Hepatitis A				
		Hepatitis B				
		Meningitis				
		Influenza				
		Other (i.e., HIB)				

Medical History

Do you currently have or have you ever been treated for any of the following?

Yes	No	Condition	Explain
		Asthma Last attack: _____/_____	
		Diabetes Last HbA1c: _____.____%	
		Hypertension (high blood pressure)	
		Heart disease/heart attack/chest pain/heart murmur	
		Stroke/TIA	
		Lung/respiratory disease	
		Ear/eyes/nose/sinus problems	
		Muscular/skeletal condition/muscle or bone issues	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Behavioral/neurological disorders	
		Bleeding disorders	
		Fainting spells and dizziness	
		Thyroid disease	
		Kidney disease	
		Blood disorders/sickle cell disease	
		Seizures Last seizure: ____/____/_____	
		Obstructive sleep apnea/sleep disorders	Use CPAP: Yes No
		Abdominal/stomach/digestive problems	
		Surgery	
		Serious injury	
		Excessive fatigue	
		List any other medical conditions not covered above	

Informed Consent, Release Agreement, and Authorization

I understand that participation in RYLA activities involves the risk of personal injury, including death, due to the physical, mental, and emotional challenges in the activities offered. Information about those activities may be obtained from the RYLA Coordinator. I also understand that participation in these activities is entirely voluntary and requires participants to follow instructions and abide by all applicable rules and the standards of conduct.

I further understand, that failure to comply with all RYLA rules and instructions from RYLA staff and/or possession of tobacco, alcohol, vaping supplies, and/or illegal drugs may result in the removal of my child from participation in camp activities. I agree to pick my child up from camp as soon as possible after their removal.

In case of an emergency involving my child, I understand that efforts will be made to contact the individual listed as the emergency medical contact. In the event that this person cannot be reached, permission is hereby given to the medical provider selected by the RYLA Chair or Coordinator to secure proper treatment, including hospitalization, anesthesia, surgery, or injections of medication for me or my child. Medical providers are authorized to disclose protected health information to the adult in charge, camp medical staff, camp management, and/or any physician or health-care provider involved in providing medical care to the participant. Protected Health Information/Confidential Health Information (PHI/CHI) under the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. §§160.103, 164.501, etc. seq., as amended from time to time, includes examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participant's parents or guardian, and/or determination of the participant's ability to continue in the program activities.

(If applicable) I have carefully considered the risk involved and hereby give my informed consent for my child to participate in all activities offered in the program. I further authorize the sharing of the information on this form with any RYLA volunteers who need to know of medical conditions that may require special consideration in conducting RYLA activities.

With appreciation of the risks associated with programs and activities, on behalf of my child, I hereby fully and completely release and waive any and all claims for personal injury, death, or loss that may arise against the RYLA, Rotary District 5630, Rotary District 5610, Rotary International, related parties, or other organizations associated with any program or activity.

I also hereby assign and grant to the RYLA program, as well as their authorized representatives, the right and permission to use and publish the photographs/film/videotapes/electronic representations and/or sound recordings made of me or my child at all RYLA activities, and I hereby release the RYLA program, District 5630, District 5610, Rotary International, related parties, or other organizations associated with the activity from any and all liability from such use and publication. I further authorize the reproduction, sale, copyright, exhibit, broadcast, electronic storage, and/or distribution of said photographs/film/videotapes/electronic representations and/or sound recordings without limitation at the discretion of the RYLA program, and I specifically waive any right to any compensation I may have for any of the foregoing.

Due to the nature of programs and activities, the RYLA program cannot continually monitor compliance of program participants or any limitations imposed upon them by parents or medical providers. However, so that volunteers can be as familiar as possible with any limitations, list any restrictions imposed on a child participant in connection with programs or activities below.

☐ **None** ☐ **List restrictions, if any** _____

I certify that the information contained in this medical form is accurate. I understand that, if any information we have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

Participant's Printed Name _____ **Participant's Signature** _____

Parent/guardian's signature _____ **Date** _____/_____/_____

Immunization Exception Request

The information below is only needed if immunization exception request is needed.

On religious, philosophical, or medical grounds, I request exemption for my child from all vaccinations and/or immunizations required by Great Plains RYLA for attendance to Great Plains RYLA Camp operated by Rotary District 5630 and District 5610 . I understand that a medical evaluation and screening by a licensed health-care practitioner is necessary to reduce the possibility of exposing other camp participants to a communicable disease.

In consideration of these exemptions, I understand that I accept complete responsibility for the health of my child, and I hereby release and agree to hold harmless Rotary District 5630 and Rotary District 5610 and any of its officers, agents, and representatives from any liability that might arise during RYLA activities by virtue of this exemption. It is further understood that should an emergency arise,

First and Last Name _____

Telephone (_____)_____
will be notified immediately. In the event that this contact cannot be located immediately, Great Plains RYLA authorities may take such temporary measures as they deem necessary.

_____ _____

Participant signature **Parent/guardian signature**

Date:_____/_____/_____

Student Name (print): _____

Address: _____

City _____ State _____ Zip_____

Physical Examination

This section to be completed and signed by a certified and licensed health-care provider

An approved school or activity physical form can be substituted for this information.

Height (Inches) _____ Weight (Pounds) _____ BMI _____Blood pressure _____Pulse_____

	Yes	No	Explain
Medical restrictions to participate			

Allergies or Reactions	Yes	No	Explain
Medication			
Food			
Plants			
Insect bits/stings			

	Normal	Abnormal	Explain any Abnormalities
Eyes			
Ears/nose/throat			
Lungs			
Heart			
Abdomen			
Genitalia/hernia			
Musculoskeletal			
Neurological			
Other			

Examiner's Certification

I certify that I have reviewed the health history and examined this person and find no contraindications for participation in a the RYLA Camp experience. This participant (with noted restrictions):

True	False	Explain
		Does not have uncontrolled heart disease, asthma, or hypertension.
		Has not had an orthopedic injury, musculoskeletal problems, or orthopedic surgery in the last six months or possesses a letter of clearance from his or her orthopedic surgeon or treating physician.
		Has no uncontrolled psychiatric disorders.
		Has had no seizures in the last year.
		Does not have poorly controlled diabetes.

Health-care provider printed name _____

Address _____ City_____ State_____ Zip_____

Office Phone (_____) _____-_____

Examiner Signature _____Date _____/_____/_____