

# KROKA EXPEDITIONS PHYSICAL, MEDICAL & EMERGENCY INFORMATION

659 West Hill Road, Putney, VT 05346 / phone 802.387.5397 / fax 802.387.4536 / krokavt@gmail.com / www.kroka.org

- **To be completed by parent(s). A doctor's signature is NOT needed.**
- **Please do not leave any questions blank. Mark "none" or "no" if a question does not apply. This form contains important information to help us work with your child. Incomplete forms will be returned.**

Program Name \_\_\_\_\_ Program Dates \_\_\_\_\_

Student Name \_\_\_\_\_ Gender \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age at program start \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Shoe size \_\_\_\_\_

Allergies (Please bring an Epi pen if allergic to bee stings) \_\_\_\_\_

Please rate the severity of the above allergies:      mild                      moderate                      severe (life threatening)

Please describe in detail allergic reaction \_\_\_\_\_

Dietary Restrictions \_\_\_\_\_

Is student taking any medication? YES / NO If yes, what kind(s)

\_\_\_\_\_ For what conditions \_\_\_\_\_

***Instructors administer all medications unless other arrangements are made. Please provide written instructions below regarding dosage, frequency and potential side effects. These instructions will be taken on the trip and followed by staff. Please be specific. Please use additional paper if needed.***

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## MEDICAL EMERGENCY INFORMATION

Doctor's Name \_\_\_\_\_ Office \_\_\_\_\_  
Phone \_\_\_\_\_

Medical Insurance Carrier\* \_\_\_\_\_  
Phone \_\_\_\_\_

Medical Insurance Policy  
Number \_\_\_\_\_

***\*If you are uninsured, please read and sign the following:***

Having no insurance, I assume all financial responsibility for the cost of any medical treatment that may be a result of my child's participation in a Kroka Expeditions program.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## EMERGENCY CONTACTS - please print clearly.

1. Parent Name \_\_\_\_\_ Day phone \_\_\_\_\_

#(\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Night phone \_\_\_\_\_

#(\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_ Cell phone \_\_\_\_\_

#(\_\_\_\_) \_\_\_\_\_

2. Parent Name \_\_\_\_\_ Day phone \_\_\_\_\_

#(\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Night phone \_\_\_\_\_

#(\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_ Cell phone \_\_\_\_\_

#(\_\_\_\_) \_\_\_\_\_

*Please provide the name and phone number of one more emergency contact person:*

3. Name \_\_\_\_\_ Day phone \_\_\_\_\_

#(\_\_\_\_) \_\_\_\_\_

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Relationship \_\_\_\_\_ Night phone #(\_\_\_\_\_) \_\_\_\_\_

**I hereby give permission for any emergency treatment, should it become necessary.**

\_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of parent or guardian for students under 18 years old

## ADDITIONAL QUESTIONS

Please describe your child's

appetite. \_\_\_\_\_

Please list any past or current conditions that may limit student's participation in any activity. \_\_\_\_\_

How does your child deal with stress and get along with other people? \_\_\_\_\_

Is this your child's first overnight camp experience? YES / NO

Are you concerned about homesickness? YES / NO

Please

elaborate. \_\_\_\_\_

We would like to know anything unique/special/different about your child that may affect this experience for her/him, other students, or staff. With staff knowledge prior to the program, the experience for all, most importantly your child, will be much more enjoyable. Please use additional paper if needed. In addition, please feel free to call and speak with your child's program teacher.

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