

BLACK SWAMP BIRD OBSERVATORY
Health History and Examination Form
For Youth and Adults Attending
Camps and Overnight Field Trips



Name _____

Birth Date _____

Home Address _____

Social Security Number of Participant _____

Custodial Parent/Guardian _____

Address _____ Phone _____

Second emergency contact _____

Address _____ Phone _____

Relationship to participant _____

Insurance Information

Is the participant covered by family medical/hospital insurance? Yes No

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

Carrier Address _____

Name of Insured _____ Relationship to participant _____

Social Security number of policy holder or insurance ID number _____

Participant's Medical Information

All known Allergies

Describe reaction and management of reaction

Medication being taken

Return to: BSBO, 13551 W. State Route 2, Oak Harbor, Ohio 43449

EMERGENCY MEDICAL AUTHORIZATION FORM O.R.C. 3313.712



Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who will become ill or injured while under Observatory authority, when parents or guardians cannot be reached.

Student Name _____
Please Print Last First

Address _____

Telephone _____ Grade _____

Birth Date _____

Residential parent or guardian _____

Mother's Name _____
Please Print Last First

Father's Name _____
Please Print Last First

Guardian's Name _____
Please Print Last First

To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be contacted:

Physician _____ Phone _____
Dentist _____ Phone _____
Medical Specialist _____ Phone _____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give Black Swamp Bird Observatory representatives my consent for (1) the administration of any treatment deemed necessary by the above named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to a hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists, concurring on the necessity of such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted. _____

Signature of Parent or Guardian _____

Date _____