Program Medical Form

Please return this form (pages 5-8) with physician's signature to: New Adventures, 393 S Harlan St, Suite 250, Lakewood, CO 80226 Attn: Desiree Romero OR upload it as part of your online application.

_____ _____
(Participant's Name) (Program/s)

Application will be returned if incomplete. Please note Medical Form is (4) pages in length.

Medical History

1. Are the applicant's immunization records up-to-date and complete? Yes No
   If the applicant is under 18 years old, please attach a copy of the records.
2. Date of last tetanus shot_____ (Mandatory Information)
3. Has there been any recent exposure to contagious diseases? Yes No
   a. If yes, please explain:
4. How would you assess the applicant's current health? Good Fair Poor
5. List any chronic health problems (e.g., asthma, pressure sores, cough, constipation) and treatments of which the medical staff should be aware:
6. Is the applicant a carrier of Hepatitis B or has he/she been exposed to Hepatitis B? Yes No
   a. If yes, was a lab test conducted to determine the presence of antibodies? Yes No
   b. Were antibodies present? Yes No
   c. Physician's Initials_____
7. Is the applicant a carrier of any other infectious or contagious condition? Yes No
   a. If yes, please explain:
8. Does the applicant have any known allergies? Yes No
   a. If yes, please describe:
9. Does the applicant have seizures? Yes No
   a. **If yes, please answer the following:**
      Current status (i.e. active, controlled):_____
      Type of seizure, how often: _____

Medications:

A complete medication profile is necessary in the event of an emergency. Include all prescribed and over-the-counter medications the participant may take (even while not attending New Adventures) including creams, sunscreens, acetaminophen, and ibuprofen.

Medication #1:_____ Dose:_____

Times given: _____ To be given at New Adventures? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #2:_____ Dose:_____

Times given: _____ To be given at New Adventures? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #3:_____ Dose:_____

Times given: _____ To be given at New Adventures? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #4:_____ Dose:_____

Times given: _____ To be given at New Adventures? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #5:_____ Dose:_____

Times given: _____ To be given at New Adventures? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication #6:_____ Dose:_____

Times given: _____ To be given at New Adventures? No ☐ Yes ☐

How to administer the dose: _____

Reason prescribed: _____

Medication Policy

The New Adventures Nurse may only administer medications under the direction of the participant's physician. All medications must be given to the New Adventures Nurse for safe storage.

Prescribed medications must be in the original container and include the original pharmacy label.

Over the counter medications (such as diaper creams, sunscreens, Tylenol for headaches, etc.) must be in the original container. A written prescription from the health care provider for the medication must be on file. The medication will be given only for the reason prescribed by the health care provider.

I understand that I must supply New Adventures with any prescribed or over the counter medications to be given to the participant.

All documented prescriptions from the health care provider will remain valid for the New Adventures Year, September to May, unless otherwise noted by the health care provider. Medications expired by the manufacturer or pharmacy label cannot be given to the participant. I understand that medication will be destroyed if not picked up within one month following termination of the order or May 31st of the year, whichever comes first.

I have read and understand the Medication Policy and hereby request medications to be administered by New Adventures personnel.

_____

Signature of Parent/Legal Guardian/Date

PHYSICIAN'S CONSENT AND SIGNATURE

When seen by me on this date, the above-named applicant was free from any contagious or infectious diseases or conditions and can participate in the New Adventures.

Physician Signature:_____ Date:_____

Physician's Name (Please Print):_____

Office Phone:_____ Emergency Phone: _____

_____

Address City State Zip

Administration of Medication Authorization at New Adventures

Colorado State Law and Regulations require a written medication order from an authorized prescriber, (physician, dentist, advanced practice registered nurse or physician's assistant) or the nurse or designated trained personnel to administer medication.

Complete *one form* for *each medication* to be administered at New Adventures, including any over the counter medications (such as diaper creams, sunscreens, Tylenol).

Prescriber's Authorization

Name of Participant: _____ Date of Birth: _____

Address: _____

Condition for which drug is being administered: _____

Drug Name: _____ Dose: _____ Route: _____

Time of Administration: _____ If PRN, frequency: _____

Relevant side effects: None expected Specify: _____

ALLERGIES: NO YES (*specify*): _____

Medication shall be administered from: _____ to _____
Month / Day / Year Month / Day / Year

Prescriber's Name/Title: _____
(*Type or print*)

Telephone: _____ Fax: _____

Address: _____

_____

Use for Prescriber's Stamp

Prescriber's Signature: _____ Date: _____