FWS Form 3-2525 (Rev. 07/2020)
U.S. Department of the Interior

OMB Control No. 1018-####
Expiration Date: ##/##/20##

Native Youth Community Adaptation and Leadership Congress
Student Medical Information
Print Clearly

Student's Full Name: _____ Student's Preferred Name/Nickname: _____

Date of Birth: _____ Age: _____

Is your child covered by Public Health Insurance? ____ Yes ____ No
(i.e. Medicaid, CHIP or Indian Health Service (IHS)
If yes, name of public health insurance: _____

Is your child covered by private health insurance? ____ Yes ____ No
If yes, name of child's health insurance provider:

_____

_____ _____
Policy Holder's Name Insurance Policy Number

_____ _____
Group or Member Number Prescription Card Number

_____ _____
Student's Home Doctor/Other Provider Name Doctor/Provider's Phone Number

Medical Information:

List Medications Required by Student (both Prescription and Non-Prescription

Medication	Dose	Frequency
Medication	Dose	Frequency
Medication	Dose	Frequency

My child is aware that they may not share any medication with other campers.
Participant Initials:_____

Drug sensitivities/allergies (circle if severe)_____

Epi-pen: Does your child require an Epi-pen to treat an allergy? ____Yes ____No
If yes, please make sure to send at least two Epi-pens along with your child.

Asthma: Does your child use an inhaler for asthma? ____ Yes ____No
If yes, my child has been instructed to carry their inhaler to **ALL** camp activities. Initial_____

Tetanus: Date of last tetanus _____

Pre-existing conditions:

Does your child have any injuries or conditions that presently exist that would limit them from any physical activities? ____ Yes ____ No

If yes, describe _____

Has your child had any sports or orthopedic (muscle, joint, etc) injury within the past year?

____Yes ____No If yes, describe _____

Does your child have any emotional health or behavioral issues? ____ Yes ____ No

If yes, explain _____

Has your child been diagnosed with any other significant chronic illness (diabetes, heart, epilepsy, etc?) ____ Yes ____ No

If yes, describe _____

Is participant currently pregnant or has she been pregnant within the past year?

____Yes ____ No If yes, list dates _____

Other Health information will not be shared except with medical practitioners, should circumstances warrant. For example, include for your child any recent hospitalizations, injuries, illness, infectious diseases, or any chronic or recurring illness or conditions such as allergies:

List Student Food Allergies:_____

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Prescription Medications Statement:
ALL student medications will be registered and handed to the NYCALC Health Care Coordinator/Nurse upon arrival. Prescription and over-the-counter medications are only dispensed by the Nurse or designated staff members. All medications must be given to the Nurse upon arrival at the National Conservation Training Center (NCTC). Students are allowed to keep vitamins, topical creams, inhalers for asthma, and Epi-pens in their room.

Over-the-Counter Medicines Available at NCTC as needed:
The following list are examples of over-the-counter medications that may be made available to students at NCTC as deemed appropriate by the nurse:
Acetaminophen (Tylenol); Bio Freeze (muscle pain relief); Blistex; Calamine Lotion; Chloraseptic; Cough Drops; DayTime Cold & Flu; Diphenhydramine (Benadryl); Epinephrine (Epi Pen); Guiafenessen (Robitussen); Hydrocortisone Cream; Ibuprofen (Advil); Immodium AD (diarrhea relief); Ivy Rid (Benzocaine); Loratadine (Claritin/Claritin D); Maalox; Milk of Magnesia; Naproxen Sodium (Aleve); NightTime Cold & Flu; Pepto-Bismol; Pseudoephedrine HCL (Sudafed); Silver Sulfadiazine (Burn Ointment); Super Blue Stuff (Sore Muscles, Bruises, Sprains); Tolnaftate - Tinactin (to treat athlete's foot fungus); Triple Antibiotic Ointment (to treat scrapes to prevent infection)

In the event that I, the child's parent/guardian, cannot be reached in case of a medical emergency, I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment.

I give permission for my child to be treated for minor scraps, bruises, cuts, and skin irritations by National Conservation Training Center staff and the use of over-the-counter medicines.

_____
Print Parent/Guardian Name

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Emergency Phone Number

Paperwork Reduction Act Statement: We are collecting this information subject to the Paperwork Reduction Act (44 U.S.C. 3501) to assure the health and safety of participants while on site at the National Conservation Training Center for the Congress. Your response is voluntary and we will not share your response publicly. We may not conduct or sponsor and you are not required to respond to a collection of information unless it displays a currently valid OMB Control Number. OMB has reviewed and approved this focus group and assigned OMB Control Number 1018-####.

Estimated Burden Statement: We estimate it will take 30 minutes to complete this form, including time to read instructions and gather information. You may submit comments on any aspect of this information collection to the Service Information Collection Clearance Officer, U.S. Fish and Wildlife Service, 5275 Leesburg Pike, MS: PRB (JAO/3W), Falls Church, VA 22041-3803, or via email at Info_Coll@fws.gov. Please do not send your completed form to this address.