LILLARD FLY FISHING
EXPEDITIONS

Students Name:

HEALTH RECORD – AUTHORIZATION

INSTRUCTIONS TO THE PARENTS: Please complete and sign page 2 of the Health Record and then give your physician pages 3 and 4 to complete. Please return these forms to Lillard Fly fishing Expeditions by May 1st. (If you receive these forms after April 15th please return all forms within 30 days)

Please note: Although the final due date for the Health Record form is May 1st, it is beneficial to turn it in earlier. As soon as we receive and review this form along with the School Reference, we will either notify you that your acceptance is confirmed and that you may purchase a flight, or we will call you with any questions.

A physical exam performed within the past 12 months is required.

INSTRUCTIONS TO THE PHYSICIAN: Please complete and sign the Health Record (Prescription Medications and Physician Report Pages). These forms may be returned to the family for submittal to Lillard Fly Fishing Expeditions or you may submit them directly to Lillard Fly Fishing Expeditions either by email (enrollment@lillardflyfishing.com) or mail (Lillard Fly Fishing Expeditions 2540 King Rd. Pisgah Forest, NC 28768) by May 1st. Thank you.

Students Name:

HEALTH RECORD – PRESCRIPTION MEDICATIONS

(To be completed by a parent/guardian and signed by the physician if necessary)

INSTRUCTIONS TO THE PARENTS: Please complete and sign this page of the Health Record and then give your physician pages 3 and 4 to complete. Please return these forms to Lillard Fly Fishing Expeditions via email or mail by **May 1st**.

My child, _____ **WILL NOT** bring prescription medications on his/her Lillard Fly Fishing Expeditions program. If this is the case, the physician signature at bottom of this page is not required.

My child, _____ **WILL** bring the following prescription medications on his/her Lillard Fly Fishing Expeditions program. If this is the case, physician signature at bottom of this page is required.

Please indicate if your child is bringing an inhaler on his/her LILLARD FLY FISHING EXPEDTIONS program.

Inhaler brand _____ Fast-Acting Rescue*
OR Daily Use Maintenance (please circle one)

* If Fast-Acting Rescue: Would you prefer to have your child hold on to it for the duration of the program? YES NO

Please list all medications your child will bring on his/her Lillard Fly Fishing Expeditions program and record dosing instructions accurately.

Medication #1 _____ Purpose _____
Instructions _____ Expiration _____
Medication #2 _____ Purpose _____
Instructions _____ Expiration _____
Medication #3 _____ Purpose _____
Instructions _____ Expiration _____
Medication #4 _____ Purpose _____
Instructions _____ Expiration _____

Prescribed medications need to be kept in original containers bearing the pharmacy label, showing date of filling, pharmacy name and address, filling pharmacist's initials, serial number of the prescription, name of the patient, name of the prescribing practitioner, name of the prescribed medication, directions for use and cautionary statements, if any, contained in such prescription or required by law, and if tablets or capsules, the number in the container. All over-the-counter medications must be kept in the original containers with the original label, which must include the directions for use. Your child's Lillard Fly Fishing Expeditions leaders are required to hold/administer all medications during the program. Any changes to prescribed medications must be submitted in writing to Lillard Fly Fishing Expeditions and authorized by you and your child's physician before the start of your child's Lillard Fly Fishing Expeditions program.

Please Note: For enrolled students who are taking medications that treat behavioral, emotional or attention disorders, discontinuation of medications before or during their Lillard Fly Fishing Expeditions program is not permitted.

PARENT/GUARDIAN SIGNATURE _____ DATE _____

To the Physician: Law requires approval in writing from a licensed physician for the administration of prescription medication brought from home on a Lillard Fly Fishing Expeditions program. I give permission for the administration of the medications as specified above, to the student listed above.

LICENSED PHYSICIAN SIGNATURE _____ DATE _____
PRINTED NAME OF PHYSICIAN _____ PHONE _____
ADDRESS _____

PLEASE CONTINUE ON THE FOLLOWING PAGE →

Students Name:

Due May 1st

HEALTH RECORD - PHYSICIAN'S REPORT (page 1 of 2, to be completed by the physician)

STUDENT'S NAME _____ DATE OF BIRTH _____

ADDRESS: _____

Lillard Fly fishing Expeditions programs offer age-appropriate challenges for young people; the programs demand excellent physical health, mental health and social skills. Lillard Fly Fishing Expeditions' admissions team screens for significant physical and psychological health issues to ensure the safety and success of all students. THIS STUDENT'S PARENTS HAVE AUTHORIZED YOU TO RELEASE THE FOLLOWING INFORMATION TO US. Your complete disclosure of this student's health history, medical and psychological records is appreciated. The information you provide will assist us in determining the suitability of the student for the program in which he/she is enrolled.

1. **Has this student ever been diagnosed, treated or exhibited symptoms of any of the following?** Please check YES or NO below. If YES, on an attached sheet please provide the treatment and dates, and the name of the treating physician or health professional.

	YES	NO		YES	NO
ADD or ADHD			Sleep Disorder		
Eating Disorder			Mood Disorder		
Depression			Obsessive Compulsive Disorder		
Suicidal Thoughts or Tendencies			Conduct Disorder		
Anxiety, Panic Attacks or Phobias			Development Disorder		
Schizophrenia			Autism		
Bipolar Disorder			Asperger's Syndrome		

2. **Is this student currently under the care of a physician, psychologist, psychiatrist, counselor, therapist or health professional for emotional, psychological, behavioral or adjustment issues?**

Please circle one: YES NO If YES, on an attached sheet please provide diagnosis, treatment and dates, and the name and contact information of the treating physician or health professional.

3. **Is this student currently taking medications for emotional, psychological, behavioral or adjustment issues?**

Please circle one: YES NO If YES, on an attached sheet please provide a list of medications, diagnosis, and the name and contact information of the prescribing physician or other health professional.

4. **Has this student ever exhibited symptoms of, been treated, diagnosed, or prescribed medications for any other emotional, psychological, behavioral or adjustment issues?**

Please circle one: YES NO If YES, on an attached sheet please provide the diagnosis, treatment, medication, dates, and the name and contact information of the treating physician or healthcare provider.

5. **To the best of your knowledge:** (Please circle your response) If YES, please explain on an attached sheet.

a) Does this student smoke cigarettes or use any other tobacco products? YES NO

b) Does this student abuse alcohol? YES NO

c) Does this student abuse drugs? YES NO

6. **Is this student** (Circle one):

Normal Weight Moderately Underweight Moderately overweight
Significantly underweight Significantly overweight

LICENSED PHYSICIAN SIGNATURE _____ DATE _____

PRINTED NAME OF PHYSICIAN _____

PHONE _____ ADDRESS _____

PLEASE CONTINUE ON THE FOLLOWING PAGE →

Due May 1st

Students Name:

HEALTH RECORD - PHYSICIAN'S REPORT (page 2 of 2)
(To be completed by the physician)

STUDENT'S NAME _____DATE OF BIRTH _____

7. **Does this student have any hearing, sight or speech impairments?** Please circle one:
YES NO If YES, please explain on an attached sheet.

8. **Does this student have any difficulties participating in physical activities?** Please circle one:
YES NO If YES, please explain on an attached sheet.

9. **Has this student had any operations or injuries?** Please circle one:
YES NO If YES, please explain on an attached sheet.

10. **ALLERGIES**: Check all that apply:
☐ No Known Allergies

If any allergies checked below, please describe on an attached sheet.
☐ Food Allergy
☐ Medicine Allergy
☐ Environmental (insect, hay fever, etc.)

Other Allergies.

DIETARY: Circle all that apply: No Dietary Restrictions Eats a vegetarian diet
Dietary restrictions - if circled, please describe on attached sheet

12. **Is this student undergoing treatment at this time for any condition?** Please circle one:
YES NO

If YES, please explain on an attached sheet and indicate if treatment will be continued during his/her Lillard Fly Fishing Expeditions program.

13. **PHYSICAL EXAM**: Please note that we can only accept physical exams completed within the past 12 months.

Was a physical exam done today? YES-Date _____NO-Date of most recent exam _____
Weight _____ Height _____ BP _____/_____

14. **IMMUNIZATIONS**: List the month/year of immunizations or attach record of immunizations given.

Diphtheria, tetanus, pertussis (DtaP) or (TdaP)						Meningococcal (MCV4)		
Mumps, Measles, Rubella (MMR)						Tetanus booster (dT) or (TdaP)		
Haemophilus influenzae Type B (HIB)						Varicella Had Chicken Pox		
Pneumococcal (PCV)						Hepatitis B		
Polio (IPV)						Hepatitis A		
TB Risk: High Low	Mantoux TB Test within last 6 mos:							

LICENSED PHYSICIAN SIGNATURE _____DATE _____
PRINTED NAME OF PHYSICIAN _____
PHONE_____
ADDRESS_____
_____

Due May 1st