HARVEST MEDICAL AND INSURANCE FORM

XEROX 2 COPIES & RETURN THE ORIGINAL AND 1 COPY

Due July 29, 2016

KEEP A COPY AND BRING IT WITH YOU

YOU MUST HAVE THIS FORM COMPLETE TO PARTICIPATE IN HARVEST

Name _____

Address _____

Telephone _____

Person to notify in case of emergency: (Please write clearly)

Name: _____ Relation to you: _____

Address: _____

Telephone (day & night): _____

Backup person to notify in case of emergency: _____ Relation to you: _____

Telephone (day & night): _____

Primary physician: _____

Telephone: _____

Insurance:

Do you have the Yale Health Plan? _____

If you waived the YHP, what is your health insurance coverage? _____

Policy Number: _____

Expiration date: _____

Do you have any dietary restrictions food allergies, or medical allergies? Describe: _____

_____

_____

CONSENT & WAIVER

Please read carefully and sign below:

I, _____ will participate in the 2016 HARVEST PROGRAM. I hereby acknowledge that I have voluntarily and freely elected to participate in HARVEST, and that I am not required to do so. I acknowledge that there may be risks associated with my participation in the HARVEST by virtue of being outdoors and on a farm, for example: operating ladders while picking apples, swimming without a lifeguard, etc. I understand that it is my decision whether or not to participate in such activities, and that I choose to do so at my own risk. I understand and agree that HARVEST, Yale University and/or its representatives assume no liability in the event of accident or illness, nor for damage or injury to the person or property of any nature whatsoever. By participating in HARVEST, I voluntarily and freely assume all risk of accident, injury, illness, or damage to or loss of property. HARVEST and/or Yale University shall not be responsible to any person for any of my acts of omissions. I agree to release, indemnify, and hold harmless, HARVEST, the Yale Sustainable Food Project, Yale University, and its representatives from and against claim which I, my parents or guardian or any other person may have for any losses, damages or injuries arising out of or in connection with my participation in HARVEST even if caused by the negligence of the HARVEST, Yale Sustainable Food Project, Yale University and/or its representatives. In the event of an emergency in which I require medical care, I understand that reasonable attempts will be made to reach m y parents or guardians for such permission. If my parents or guardians are unable to be reached, I give permission to the health care provider treating me to order appropriate medical care.

I certify that I have read and agree to all of the above

Signature of Student Date

I certify that I am the parent or guardian of the student who signed above, and that I have read and agree to all of the above.

Signature of Parent/Guardian (required if under 18) Date

HARVEST MEDICAL FORM—PART II
TO BE COMPLETED BY A PHYSICIAN

Student's Name_____
Birth date_____Height_____Weight_____

1. Please list any allergies (be specific, list any foods or mediations used, especially BEE STINGS, PENICILLIN)

_____
_____

Please note: We have been experiencing students arriving with more allergies. Please assess this as thoroughly as you can.

2. Is student taking any regular medication of any sort? _____Yes _____ No

3. Date of last Tetanus shot: _____

4. Does the student have any physical handicaps? Problems with hearing or vision? Asthma? Diabetes? Bad knees? Reactions to temperature extremes? Muscle cramps? Seizures? High or low blood pressure? Heart condition? Fear of heights or confined places? (None of these will necessarily prohibit the student's participation, but for safety reasons we must be aware of such conditions.)

_____
_____
_____

5. List any recent illnesses:

_____
_____

6. On the basis of your knowledge of the student's medical history and this examination, do you advise any limitations on participation in physical activities such as working on a farm for four to six days? Students in the program will be working and participating in activities outdoors, often in heat and sun, for 6-8 hours per day. We need to know if, in your opinion, there is anything in the student's medical background that would preclude or limit his or her participation. Please be as specific as necessary in noting the problem and the limitations it might impose.

Comment:

_____
_____
_____
_____

Signature of examining physician Date

Printed Name, Address, and Telephone Number:

_____
_____
_____
_____

CONTENT REQUEST

Consent is hereby given for the applicant to participate in HARVEST, and permission is given to the physician to order injection, anesthesia, or surgery for the applicant in case of emergency when the parents cannot be reached. Authorization is given to the HARVEST program to review the information about the applicant provided the University Health Services.

Signature of Parent or Guardian Date

Signature of Student Date

Please remember to send the **original & one copy** of this form to:

HARVEST
c/o Yale Sustainable Food Project
PO Box 208270
New Haven, CT 06520-8270

(Do **NOT** send this to the Yale Health Plan)