JUST UNDERSTAND MY POTENTIAL INC.

Pre-Participation Medical Evaluation

Name: **DOB:**

IMMUNIZATIONS: PLEASE ATTACH A COPY OF THE IMMUNIZATION RECORD **OR** LIST THE IMMUNIZATIONS AND DATE RECEIVED AND SUBMIT AS AN ATTACHMENT.

Past Medical History / Current Health Issues:

- ❑ Asthma
- ❑ Seizures
- ❑ Other:

Allergies:	**YES**	**NO**	***If yes, please describe:***
Food:	❑	❑	_____
Medication:	❑	❑	_____
Other:	❑	❑	_____

Current Medications (*including name, dose, route and times of administration*):

❑ J.U.M.P. Inc. may administer ibuprofen 10mg/kg (**Max:** 400 mg) orally every 6 hours as needed for pain/fever
❑ J.U.M.P. Inc. may administer acetaminophen 15 mg/kg (**Max:** 650mg) orally every 4 hours as needed for pain/fever
❑ J.U.M.P. Inc. may administer diphenhydramine (Benadryl) 1.25 mg/kg (**Max:** 50 mg) orally every 6 hours for rash/ itching/allergy. (Alternative dosing: 6-11 years old: 12.5 - 25mg, over 12 years old: 25 - 50mg every 6 hours.)

Physical Examination: **Date of Examination:** _____

Height: _____inches or cm Weight: _____lbs or kg BMI: _____(_____%) BP: _____

❑ The entire examination was normal ***(may skip below)***

❑ General:	❑ Lungs:	❑ Extremities:
❑ Skin:	❑ Heart:	❑ Neurologic:
❑ HEENT:	❑ Abdomen:	❑ Other:
❑ Dental:	❑ Genitalia:	

The participant has the following issues which may affect his/her participation:

- ❑ Decreased vision/hearing
- ❑ Fine / gross motor deficit
- ❑ Behavioral issues
- ❑ Other:

Comments / recommendations:

May participate fully in outdoor program, including hiking/camping: ❑ YES ❑ NO
If no, list restrictions:

_____ _____ _____
Signature of Examiner **Date** **Telephone Number**

_____ _____
Print Name of Examiner **Address**

(Please attach additional information as needed for the health and safety of the participant.)