

HARVEST MEDICAL AND INSURANCE FORM
XEROX 2 COPIES & RETURN THE ORIGINAL AND 1 COPY.
DUE JULY 15, 2009

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 _____

Address _____

Telephone (day and night) _____ Relation to you _____

Backup person to notify in case of an emergency:

Telephone (day and night) _____ Relation to you _____

Family Physician _____

Telephone _____

Insurance: The Yale Health Plan will cover you during the trips unless you decide to waive the plan. Your University Health Insurance coverage starts when you arrive at Yale. If you are waiving the Yale Plan, you must be covered by your own medical insurance during the time of your trip to participate in the HARVEST PROGRAM. It is especially important for foreign students to have coverage during the trips.

Check here if you plan to use the Yale Health Plan: _____

If you are planning to waive the Yale Health Plan, what is your health insurance coverage?

_____ Policy Number _____ Expiration Date _____

Please answer the following questions:

1. What is your current physical condition? ___ poor, ___ fair, ___ good, ___ very good.

2. Do you have any dietary restrictions or food allergies? Describe: _____

3. What is your swimming ability? ___ poor, ___ fair, ___ good, ___ very good

CONSENT AND WAIVER

PLEASE READ CAREFULLY AND SIGN BELOW:

I, _____ will participate in the 2009 HARVEST program. I hereby acknowledge that I have voluntarily and freely elected participate in HARVEST, and that I am not required to do so. I acknowledge that there may be risks associated with my participation in HARVEST by virtue of being outdoors and on a farm, for example: swimming without a lifeguard, operating ladders while picking apples, etc. I understand that it will be my decision whether or not to participate in such activities, and if I do choose to participate, it will be 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 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 or omissions. I agree to release, indemnify, and hold harmless HARVEST, Yale University and its representatives from and against any 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 HARVEST even if caused by the negligence of HARVEST, 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 my 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

Date

Printed name

(This is required even if student is over 18)

**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 medications 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
If yes, please specify (list drugs used and purpose): _____

Please note: If the student is allergic to bee stings, they should carry their own bee sting kit.

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:

CONSENT 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 to 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!)