



Dreams Take Flight Atlantic Child Medical Release Form

This child is being considered for a trip to a Disney Theme Park in Orlando, Florida with Dreams Take Flight Atlantic.

The entire journey, from arrival at the airport until return, can last up to 24 hours. Children will arrive at the airport very early in the morning and return the same day near midnight. The trip through the amusement park may be fast paced and participants may be exposed to food and hot weather that they are not familiar with.

1. Will this child be able to tolerate such a rigorous trip (ie, walk independently)? Yes No

2. Does this child have any allergies? Yes No

If yes, please list allergies, reactions, and treatment.

3. What medical conditions and/or problems does this child have? Please list diagnoses.

4. What medications does this child take? (Please use the back of the form for additional medications that don't fit in the table)

Medication Name	Amount to be given (ml/mg)	How is the medication given? By mouth (pill), Injection (needle), or inhalation (inhaler)	Scheduled time for medication or just when needed/PRN	Miscellaneous Info (ie, does the medication require re Fridgeration)
1.				
2.				
3.				



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5. Can the child self administer the medication? Yes No

If no, who should administer the medication? _____

6. Does the child require any medical devices? (ie, insulin pump) Yes No Device name _____

7. Will a 25-30% reduction in the ambient partial pressure of oxygen affect this child's medical condition? Yes No

8. Is oxygen needed in flight? Yes No If yes, how many liters per minute of oxygen is required? _____

9. Does this child have anemia? Yes No If yes, what is their hemoglobin level? _____

10. Does this child need assistance with toilet/diaper changing? Yes No

11. Will this child require any additional care from a health care provider during this trip? Yes No

Please give details.

12. Please list any additional medical information that we need to know about this child.

13. Does this child have travel health insurance? Yes No Name of insurance _____

14. Is this child medically fit to travel by plane? Yes No

Child's Name (please print): _____ Child's Legal Guardian (Please Print) _____

Physician/Nurse Practitioner's Name (please print): _____

Physician/Nurse Practitioner's Phone Number: _____

Physician/Nurse Practitioner's Signature: _____ Date: _____

Dreams Take Flight Halifax is a non-profit organization, we would ask for your consideration in not charging for the completion of this form.

Office Use Only

Child approved by Dreams Take Flight Atlantic Medical Team Yes No Dreams Associate Signature: _____

If no, please explain. _____