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.

Child's Name (please print): _____ Child's Date of Birth: _____

Child's Weight: _____ Child's Height: _____

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. Do they require an epi-pen? ☐ Yes ☐ No

_____

_____

3. Does this child have any medical conditions and/or problems? Please list diagnoses.

_____

_____

4. If the child has a neurodevelopmental disorder or mental health disorder (i.e. ADHD, ASD, ODD, anxiety), would their current behaviour(s) require special assistance from a chaperone compared to other children of the same age?

☐ Yes ☐ No ☐ N/A

5. Please list any medications that this child takes regularly. If none, indicate N/A. Please use the back of the form for additional medications that do not 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 refridgeration)
1.				
2.				
3.				

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6. Can the child self administer the medication? ☐ Yes ☐ No

If no, who should administer the medication? _____

7. Is this child being seen/followed by other health care provider(s) (i.e. Psychiatrist, Psychologist, Neurologist, ect)?

☐ Yes ☐ No ☐ N/A

If yes, please provide the name(s) and profession(s) of the other health care provider(s).

_____

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

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

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

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

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

13. 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.

_____

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