MEDICAL INFORMATION FORM

The following questions relate to conditions that may occur while participating in outdoor activities especially when away from medical services. Please answer the following questions as thoroughly and honestly as possible so that we are prepared to deal with any problems that may arise (this form will be kept confidential).

Participant's Name:____ Gender_______________

Name of Program you registered for________________________________ Cell Phone#_________________________

Address:____

Primary Care Physician:____ City/State:_______________________________

MEDICAL INFORMATION:

Do you have any allergies? If yes, check all that apply: ☐Foods ☐ Insect Bites ☐Medications ☐Other___________

Please describe your reaction/s: ____

List all medications currently being taken:

Medication	Dosage	Frequency	Condition for which being taken

Please list all current medical problems and treatments (use reverse side if necessary):____________________

____

Dietary Restrictions/Allergies to foods? (ie: vegetarian celiac, tree nuts etc...)_______________________________________

____

Date of last Tetanus Booster (Tdap, DTaP) within the last 5-10 years:____

IN CASE OF EMERGENCY CONTACT:

Name:____ Relationship:____________________________

Address:____

Contact #'s

Cell_____________________________ Home:____________________________________ Work: _____________________________

MEDICAL INSURANCE:

Insurance Company Name:____________________________________ Policy No.:____

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD WHEN RETURNING THIS FORM.

Signature of Participant:____ Date:____________________________________

Signature of Parent/Guardian if child is under 18 years of age: ____