



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:

Covid-19 Vaccine _____ **Yes or No** _____

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 within the last 5-10 years: _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship: _____

Cell _____ Home: _____ Work: _____

MEDICAL INSURANCE:

Insurance Company Name: _____ Policy No.: _____

Signature of Participant: _____ Date: _____

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