MEDICAL HEALTH FORM

The information on this form will be confidential and used only in case of an emergency.

Name as spelled on Passport:_____
Last First Middle

Address_____
Street City State Zip

DOB_____ **Sex** M____ F____ **Phone** (_____)_____

Physician_____ (___)_____
Name Phone

Emergency Contact _____
Full Name Relationship

_____
Street City State Zip

Cell (_____)_____ Home (_____)_____ Work(_____)_____

Medical Insurance. Are you covered by any hospitalization / medical care policy?

Indicate Name_____ Policy Number_____

PART II. AUTHORIZATION (parent authorization if participant is under 18)
My child takes the following prescription / non-prescription medications for the following reasons. Please include general over the counter medicines such as ***Advil, Tylenol, Benadryl, etc.***

PLEASE PRINT CLEARLY

Medication #1_____ reason _____

Dosage instructions #1 _____

Medication #2_____ reason _____

Dosage instructions #2 _____

Medication #3_____ reason _____

Dosage instructions #3 _____

_____My child has my permission to self administer the non-prescription medications per instructions listed above and the prescription medications per written doctor's orders. **Please initial if yes.**

_____I request the trip leaders administer my child's non-prescription medications per instructions listed above and the prescription medications per written doctor's orders. **Please initial if yes.**

Additional Authorization: (If you are 18 or older, you may sign this section yourself.) In the event I cannot be reached in an emergency or during my / my child's illness, I hereby give permission to the trip leaders to administer first aid to the highest level of their training / ability. In addition, I grant the trip leaders permission to refer my child to a physician, to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for the above named participant if the emergency is life threatening.

Participant Signature if over 18 _____ Date_____
Parent/Guardian Signature_____ Date_____

PART III. HEALTH HISTORY

1) **Are you allergic to any thing?** Medications, penicillin, aspirin, food, insects, bee-stings, shellfish, etc.

_____

2) **Physical Status:** Check each item yes or no (describe problem or indicate none)

Recent surgery_____ Bones recently broken (give date)_____

Weak ankles or arches_____ Headaches or convulsions_____

Reactions to extreme temperature- frostbite/heat stroke, etc._____

Chronic or reoccurring illness_____

Other limiting physical conditions_____

Might any of these affect your level of involvement? No_____ Yes_____

If yes, specify how_____

3) **Swimming Ability:**

Please indicate highest level of ability: ____excellent ____average ____poor

4) **Suggestions and/or additional information:**

Vegetarian_____ Vegan_____ Special diet _____

5) **General level of physical fitness**:_____

6) **Do you drink alcohol and/or smoke?**_____

7) Do you use recreational drugs or medical marijuana?_____

To the best of my knowledge, the above information is correct.

Signature of Trip Participant _____ Date_____

**** Signature of Parent/Guardian of participants under 18:** _____ Date_____