

MEDICAL INFORMATION FORM- DISCOVER OUTDOOR PROGRAMS

I. PARTICIPANT INFORMATION (PLEASE PRINT)

Name _____ Today's Date _____

Local Address _____

Local phone number where you can be reached: (____) _____

Male____ Female____ Height _____ Weight____ Birth Date_____ Smoker: YES NO

Emergency Contact: _____ Relation to Participant: _____

Phone #1: _____ Phone #2: _____

II. MEDICAL INFORMATION

Date of last Tetanus Booster _____

List any medication to which you are allergic: _____

List any other allergies (food, plants, bee stings): _____

Do you require and/or carry any medications for allergic reactions? YES NO

If yes, please list: _____

The Discover Program carries epinephrine bee sting kits for treatment of anaphylactic shock. In the event of an allergic reaction that progresses to a life threatening stage, it is program policy to administer this treatment.

Do you have any current and/or on-going illness or condition such as diabetes or high blood pressure? YES NO If yes, please list: _____

Do you require and/or carry medication? YES NO

If yes, please indicate: _____

Please list any joint or orthopedic problems you have: _____

Please indicate any history of heart problems including hospitalization, and treatment dates: _____

III. INSURANCE

Are you covered by any Hospitalization or Medical Care Policy? YES NO

If yes, name of insurance company issuing the policy: _____

Policy or certification number: _____

IV. SIGNATURE (if participant is under 18 years of age, parent or guardian must sign)

I fully understand the rigorous nature of the program that I am participating in. In the event of an accident or emergency that renders me unable to communicate, I grant my permission for any medical care, operations, and/or anesthesia, which might become necessary.

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(Must be signed by parent or guardian if participant is under the age of 18)