

DISCOVER OUTDOOR PROGRAMS MEDICAL INFORMATION FORM

(Adopted: December 1997)

I. General Information (please print)

Name _____ Today's Date _____

Local Address _____

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

Male () Female () Height _____ Weight _____ Birth Date _____

Smoker _____ Non-Smoker _____

Person to notify in case of injury or illness: _____

Phone Number: (_____) _____

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 ongoing 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? _____

If yes, indicate 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 that might become necessary.

Date: _____ Signature: _____