HEALTH DISCLOSURE FORM

Participant Name: ________________________ Name of Outing: ________________________
Home Address: ________________________ Date: ____________
Cell Phone: ________________________ Other Phone: ________________________

We require full disclosure of your health. The information you provide may assist us in the event of an accident. Therefore, please read it carefully; full and accurate completion of all sections is very important. This information otherwise shall be kept confidentially between the trip leader(s), the Assistant Director and health care professionals. *We do not use this information in evaluating your ability to participate in any activities*. Only qualified health professionals can make that decision. If you are at all concerned about your ability to participate in any aspect of the activity, please seek the advice of a health care professional. By completing this form you are acknowledging your awareness of the above information.

EMERGENCY CONTACT, HEALTH PROVIDER, AND INSURANCE INFORMATION:

Name: ________________________ Relationship: ________________________
Address: ________________________
Cell Phone: ________________________ Home Phone: ________________________
Doctor's Name: ________________________ Doctor's Phone: ________________________
Doctor's Address: ________________________
Insurance Company: ________________________Policy Number:________________ Type: ________

PLEASE LIST ALL INFORMATION REGARDING THE FOLLOWING:

Gender: ____________ Age: _______ Height: ___'____" Weight: _______(lbs.)

Are you under treatment for any illness or condition? _______ If yes, please name and describe: ________________________
____

Are you currently taking any medication(s)? _______ If yes, please name: ________________________
____

Do you have any allergies (food or otherwise)? _______ Are you allergic to bee stings or insect bites? _______ If yes, please explain:
____

Do you have any past relevant injuries that may affect your participation? _______ If yes, please name and describe:
____

Do you have a history of heart problems? ______ If yes, please explain: ________________________

Have you ever undergone surgery? ______ If yes, for what? ________________________
____
Dietary restrictions (vegetarian, lactose intolerance etc.) ________________________

PLEASE WRITE BELOW ANYTHING YOU FEEL WE SHOULD BE AWARE OF CONCERNING YOUR HEALTH. THANK YOU!

____
____
____
____