Personal Health and Medical History

IDENTIFICATION

Name	Date of Birth	Age	Sex
Home Address	City	State	Zip

EMERGENCY CONTACT

Name	Relationship	Phone
Name	Relationship	Phone
Personal Physician Name		Phone
Personal Health Insurance Carrier		Policy No.

MEDICAL HISTORY

Check ALL items, past or present, related to your history. Please explain any "Yes" answers.

ALLERGIES: (including food, medicines, insect, plants)? ☐ Yes ☐ No
If **yes**, please list or explain:

GENERAL INFORMATION	Yes	No		Yes	No
ADHD (Attention-Deficit Hyperactivity Disorder)	☐	☐	Heart Trouble	☐	☐
Asthma	☐	☐	Hemophilia	☐	☐
Cancer / Leukemia	☐	☐	High Blood Pressure	☐	☐
Convulsions / Seizures	☐	☐	Kidney Disease	☐	☐
Diabetes	☐	☐	Other:		

If **yes**, please list or explain:

IMMUNIZATIONS: List the date of the last inoculation for a Tetanus Toxoid:
Please also note that a Hepatitis A vaccine is highly recommended. Please see your physician.

MEDICATATION: Please list ALL medications that will be used on the trip:

If this is for a teen participant, should the teen or another team leader be responsible to administer the medication?

OTHER: Please list out any condition that may affect or limit your full participation in any of the activities (e.g. building, sport games, cooking, campfire, cleaning):

DIETARY RESTRICTIONS: Please list out any dietary restrictions:

Participant Signature _____

If participant is a minor:
Parent Signature _____

Date _____