Confidential Emergency Contact/Medical Form

(It is recommended that you keep a copy for each member at all activities and events)

This medical information may be necessary in the event of serious illness or accident. Please complete this form accurately and truthfully. The facts you disclose will be kept confidential and the information provided will be given to others only in an emergency situation. Failure to disclose accurate and complete information could compound the seriousness of an accident or illness. Attach additional pages if more space is necessary.

General Information

Name _____ Date of Birth _____

Address _____

Phone _____ Email _____

Emergency Information

Health Insurance Company _____

Policy # _____ Phone _____

Physician _____ Phone _____

Please attach a photocopy of your health insurance card.

Person(s) to Contact in the Event of an Emergency

1) Name _____ Relationship _____

Address _____

Phone _____ Email _____

2) Name _____ Relationship _____

Address _____

Phone _____ Email _____

Medications

List all over-the-counter and prescription medications, dosage, and what the mediations are used for. Clearly indicate any for which it would be critical or life-threatening if you ran out. Bring sufficient quantities plus a five-day emergency supply with you.

Current Care:

If you are currently under the care of a medical professional (physician, counselor, psychiatrist, psychologist) please indicate conditions and reasons, and explain any possible impact on participation activities:

Allergies
List all drug, severe food, bee stings and other allergies and associated symptoms as well as treatments used:

Health History

Have you had a tetanus shot in the past 5 years? (This is required.)	Y __ N __
Have you received all childhood immunizations?	Y __ N __
Are you possibly pregnant?	Y __ N __
Do you suffer from any seizures?	Y __ N __
Have you been hospitalized in the past year?	Y __ N __
Do you wear contacts, glasses or have vision problems?	Y __ N __

Do you have any of the following?

Hemophilia	Y __ N __	Diabetes	Y __ N __
Hernia/Ruptures	Y __ N __	Seizures	Y __ N __
Respiratory Problems (Asthma)	Y __ N __	Chronic Pain	Y __ N __
Ulcer or GI disorder	Y __ N __	Knee conditions	Y __ N __
Back or Neck conditions	Y __ N __	Dizzy Spells, Fainting, Convulsions	Y __ N __
Eating Disorders	Y __ N __	Depression	Y __ N __
Hearing Problems	Y __ N __	Motion Sickness	Y __ N __
High Blood Pressure	Y __ N __	Broken Bones/Dislocations	Y __ N __
Heart conditions	Y __ N __	Stomach, Kidney, Internal Problems	Y __ N __

Other _____

_____

If you answered yes to any of the above, please describe the diagnosis and treatment, as well as any impact the condition may have your ability to participate in activities:

General
Please fully describe anything in your medical history or current condition that might effect your participation in activities or that should be made known to medical personnel in case of an emergency, especially if you are incapacitated.

Explain any restriction of activity for medical reasons.

Are there any treatments you don't want performed for religious or other reasons?

Do you have any special dietary needs?

Health and Safety Certification
I am aware of all my personal medical needs, and consulted with a medical doctor about my plans if I have any serious conditions. There are no health-related reasons or problems that might require accommodation in activities except as explained above, and I have answered all questions fully and truthfully.

Signed: _____ Date: _____

Address: _____

Email : _____ Phone: _____

Parent or Guardian Signature: _____ Date: _____

(If under age 18)