

Participant Medical History (use back of form if more space is needed)

Trip you are going on and date: _____

Name: _____ Address: _____

City, State, Zip: _____ Home # () _____

Cell#() _____ Work # () _____

Personal Physician: _____ Office #() _____

List of known Allergies _____ List of current Medications _____

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Do you have any medical implants? _____ wear contacts? _____ Are you pregnant? _____ Circle and explain all your medical history (including but not limited to): Asthma, Angina, Altitude problems, Allergic reactions, Back problems, Blackouts, Chest pains, Concussions, Diabetes, Drug reactions, Dislocations, Epilepsy, Heart conditions, Seizures, Surgeries, Unusual blood Pressure (explain any circled, or possible)

Are there any other conditions that might limit your participation? _____ NO, if YES explain:

Omitting any information may jeopardize your life. In your own handwriting, write the following on the line below: "I have accurately read and completed the above."

Signature

Name (printed clearly)

Date