Medical History and Emergency Contact Information

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PLEASE PROVIDE THE FOLLOWING INFORMATION. ALL AREAS NEED TO BE COMPLETED.

PERSONAL INFORMATION

Name of Applicant:_____

Emergency Contact Information:

First	Second
Name:_____	Name:_____
Relationship:_____	Relationship:_____
Day Phone:_____	Day Phone:_____
Home/Eve. Phone:_____	Home/Eve. Phone:_____

Additional Instructions: _____

_____

Medical Coverage

Physician's Name: _____Phone: _____

Are you covered by medical insurance? **Yes** ❑ **No** ❑

Name of the insurance company: _____

Policy # _____Group #_____

Address of Insurance Company: _____

_____

ote!

Please attach a photocopy (front and back) of your medical insurance card and passport to this form

CONFIDENTIAL MEDICAL HISTORY

ILLNESSES

ILLNESSES	YES	NO	ILLNESSES	YES	NO
Asthma	❑	❑	Diabetes	❑	❑
Bleeding Gums	❑	❑	High Blood Pressure	❑	❑
Colitis	❑	❑	Migraine Headaches	❑	❑
Epilepsy (seizures)	❑	❑	Ulcers	❑	❑
Heart Disorder	❑	❑	Cancer	❑	❑
Psychiatric Illness	❑	❑	Skin Disease	❑	❑
Alcoholism/Drug Use	❑	❑	HIV/AIDS	❑	❑
Hepatitis/ Infectious Disease	❑	❑			

Other illnesses or explanation of the above: _____

_____

INJURIES

INJURY	YES	DATE	NO	INJURY	YES	DATE	NO
Head Injury	❑	_____	❑	Recurrent Ankle Injury	❑	_____	❑
Back Injury	❑	_____	❑	Recurrent Knee Injury	❑	_____	❑
Broken Bones	❑	_____	❑	Other:_____	❑	_____	❑

List broken Bones if any:_____

MEDICATIONS

Please list all medications you are currently taking.

NAME	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please explain the condition you are treating with medication:_____

_____

_____

ALLERGIC REACTIONS

Do you have any allergies, including reactions to food, penicillin, antibiotics, and any other medications?

Yes ❑ **No** ❑

If yes, please describe your allergies. _____

_____

Do you carry a personal epi-kit in case of an allergic emergency? **Yes** ❑ **No** ❑

DIETARY NEEDS

Do you have special dietary needs? **Yes** ❑ **No** ❑

Are you a vegetarian? **Yes** ❑ **No** ❑

If yes, please specify or describe the need (i.e. vegan, no dairy, no red meat, etc.)_____

_____

SPECIAL NEEDS

Do you have physical, mental, or emotional conditions, which would limit your full participation or that we should be made aware of? **Yes** ❑ **No** ❑ If yes, please describe:_____

_____

_____

_____

Signature: _____ **Date:** _____