Registration/ Pre-Course Health Record

REGISTRATION

Trip/ Course Name: ______________________________ Offering # __________

PARTICIPANT

Name ____ Daytime Telephone # (_____)______________

Age ______ DOB ___/___/___ Gender ________________ Evening Telephone # (_____)______________

Address ________________________________ Apt. ____ email ______________________________

City/State/Zip ______________________________________

EMERGENCY CONTACT

Name ____________________________________

Relationship ______________________________

Daytime Telephone # (_____)______________

Evening Telephone # (_____)______________

PHYSICIAN

Name ____________________________________

Telephone # (_____)______________

FAX # (_____)__________________

email ________________________________

INSURANCE INFORMATION

Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance. Please answer the following questions for our insurance records: DO YOU HAVE INSURANCE? Yes ☐ No ☐

Insurance Company __________________________ Policy/Certificate # __________________________

Prescription Plan # __________________________ Telephone # (_____)________________________

Allergies (Including allergies to medicines, foods, insect bites/stings, etc.) **NONE** ☐ **or…**

Allergy	Reaction	Medication Required (if any)

Current Medications (Including psychiatric medication, over-the-counter medication, inhalers, etc.) **NONE** ☐ **or…**

Medication	Taken For: (Symptom/Condition)	Dosage	Date Started	Current Side Effects

Health Profile Please describe any physical/ mental/ medical conditions (including current pregnancy, etc.) or medical history that might affect your participation. ____

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Trips- If you are participating in one of our trip offerings, please answer the following:

1. Do you have any dietary restrictions? (ie vegetarian, diabetic, allergies, etc) Yes ☐ No ☐
   If yes please describe ____
2. Do you have a tent? Yes ☐ No ☐ N/A ☐ If yes, do you have tent space to share? No ☐ Yes ☐ how many?_____

I have accurately answered all of the previous questions and I understand that failure to disclose such information could result in serious harm to my fellow participants and me. I also understand the risks of participating with any current medical conditions. It is my responsibility to ensure that I am able to physically participate in the program offering. If I have any questions, I will consult a physician.

____ _____/_____/_____

Applicant's Signature / Parent or Legal Guardian Signature (if Participant is under 18) Date

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