HEALTH HISTORY FORM

Please copy and distribute to all student and adult participants

GENERAL INFORMATION

NAME:	AGE:	TODAY'S DATE:
ADDRESS:	CITY/STATE:	ZIP:
HOME PHONE:	CELL PHONE:	

EMERGENCY INFORMATION

IN CASE OF EMERGENCY CONTACT:	RELATIONSHIP:	
ADDRESS:	CITY/STATE:	ZIP:
HOME PHONE:	WORK PHONE:	CELL PHONE:
HEALTH INSURANCE COMPANY:	POLICY#:	
DOCTOR'S NAME:	PHONE:	

MEDICAL HISTORY

DO YOU HAVE ANY **ALLERGIES?** (IF YES, PLEASE EXPLAIN):

ARE YOU TAKING ANY **MEDICATIONS** CURRENTLY? (IF YES, PLEASE LIST/EXPLAIN:)

DO YOU HAVE ANY RECENT OR RECURRING **INJURIES,** RECENT **SURGERIES,** AND/ OR **DISABILITIES?** (IF YES, PLEASE EXPLAIN:)

PREGNANT	YES	NO	STROKE	YES	NO
DIABETES	YES	NO	SEIZURES	YES	NO
HIGH BLOOD PRESSURE	YES	NO	ASTHMA	YES	NO
CHEST PAINS	YES	NO	HEART ATTACK	YES	NO
SHORTNESS OF BREATH	YES	NO	HEART DISEASE	YES	NO

ANY OTHER ACTIVITY LIMITATIONS OR CONDITIONS YOU WANT US TO KNOW ABOUT (USE REVERSE IF NEEDED):

I AFFIRM THE INFORMATION ABOVE IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND THAT I HAVE NOT WITHHELD ANY INFORMATION THAT WOULD RESULT IN A HEALTH RISK WHILE PARTICIPATING IN THE OUTDOOR EDUCATION PROGRAM.

SIGNATURE:	DATE: