CAROLINA OUTDOOR EDUCATION CENTER

Medical Information Form

The following information will be used to help your Instructors and other Medical Technicians provide assistance to you in an emergency. Failure to complete all or part of this form may make it more difficult to provide adequate care to you in an emergency, which could result in an injury or compound the damage of an injury. **This information is not used to determine whether you are physically fit to participate in this activity.**

I. General Information (Please Print)

Name _____Today's Date_____

Email address _____

Address _____

Home Phone (____)_____ Business Phone (____)_____

Gender _____ Height _____ Weight _____ Birthdate _____

Sponsoring Organization _____

II. Medical Information

Family Physician _____ Phone (_____) _____

Person to be notified in case of injury or illness _____

Relation _____ Address _____

Home Phone (____) _____ Business Phone (____) _____

Date of last Tetanus Booster _____

List any Medicines to which you are allergic _____

_____

List any other allergies (food, insect bites, poison ivy, etc.) _____

_____

Are you allergic to bee stings? _____ If yes, do you carry medicine with you? _____

Name of medicine _____ Nature of reactions?_____

III. Medical History

A. Name any illness or condition for which you are now undergoing treatment and list any medications that you are currently taking: _____

_____

B. If you have had any of the following, state the year of occurrence and the location on your body in which it occurred:

Fracture _____ Hernia _____

Dislocation _____ Sprain or Strain _____

C. Name any injuries, illness, or disability not mentioned and year of occurrence _____

_____

_____

_____

D. If you have ever been hospitalized, list date and reason for hospitalization below:

Date *Name and location of Hospital* *Illness or injury*

_____

_____

MEDICAL INFORMATION FORM (cont.)

E. **If you now have, or have had any of the following symptoms or conditions, please circle YES and underline and describe the problem. If not, circle NO.**

a) YES NO Dizziness, loss of consciousness, or recurrent headaches

b) YES NO Eye, ear, nose, throat, tonsils, or sinus symptoms

c) YES NO Impairment of sight, hearing, or speech

d) YES NO Chest pain, shortness of breath, palpitation, swelling of ankles, heart murmur, heart disease, high or low blood pressure

e) YES NO Reaction to bee stings ? mild ? severe

f) YES NO Sensitivities/Allergies to: sulfa, penicillin, or any other drug

g) YES NO Muscle, joint, knee or back pain, bursitis, arthritis, sciatica

h) YES NO History of diabetes, thyroid imbalance, hypoglycemia

i) YES NO Episodes of depression, anxiety, hysteria, nervousness

Give details in regard to any of the above questions (a-i) to which you have circled YES.

_____

_____

IV. Insurance

CAROLINA OUTDOOR EDUCATION does not provide sickness or accident insurance for participants. Therefore, it is each participant's responsibility to be covered by his/her own medical insurance.

A. Are you currently covered by any Hospitalization or Medical Care policy?_____

B. If yes, indicate name of Insurance company issuing policy _____

Policy or certificate number _____

V. Signature *(if participant is under 18 years of age, Parent or Guardian must sign).*

I fully understand the rigorous nature of this activity. In the event of an accident or emergency that renders me unable to communicate, I grant my permission for any medical care, operations and/or anesthesia which might become necessary.

_____ _____

Date Signature