

PERSONAL HEALTH AND MEDICAL RECORD

To be filled out by all Trek participants

Identification:

Name _____ Date of Birth _____ Age _____ Sex _____

Height _____ Weight _____ Name of Parent or Guardian _____

Home Phone # () _____ Work Phone # () _____

Home Address _____ City _____ State _____ Zip _____

If the person named above is not available in the event of an emergency, notify:

Name _____ Relationship _____ Ph. # () _____

Name _____ Relationship _____ Ph. # () _____

Name of personal Physician _____ Ph. # () _____

Personal health/accident insurance carrier: _____ Policy # _____

Circle **yes** or **no** for all items concerning your health history. (Explain any "Yes" answers)

Allergies: Food, Medicines, Insects, Plants Y N Explain: _____

General Information: (Explain any "Yes" answers)

Asthma Y N Cancer/Leukemia Y N Convulsions/Seizures Y N

Diabetes Y N Heart Trouble Y N Hemophilia Y N

Dentures Y N Kidney Disease Y N High Blood Pressure Y N

Fainting Y N Contact Lenses Y N

Heart Disease or Family History of Sudden Cardiac Death Y N

Explain: _____

Give details of any of the following: Serious illness, Serious injury, Disease condition, Deformity, or Surgery.

Details: _____

