EMERGENCY MEDICAL INFORMATION FORM

Please complete so that health providers can be aware of your personal health needs.
This form must be completed and carried by all participants.

Name of Participant: _____

Does participant have: (if "yes", explain)

___Yes___No ALLERGIES? _____
___Yes___No HEART CONDITION? _____
___Yes___No OTHER? _____

Is participant subject to: (If "Yes", explain)

___Yes___No HEADACHES? _____
___Yes___No SEIZURES? _____
___Yes___No MOTION SICKNESS? _____
___Yes___No FAINTING? _____
___Yes___No SLEEP WALKING? _____
___Yes___No UPSET STOMACH? _____
___Yes___No OTHER? _____

Does participant have reaction to: (If "Yes", explain)

___Yes___No BEE STING? _____
___Yes___No PENICILLIN? _____
___Yes___No OTHER DRUGS? _____
___Yes___No POISON IVY, OAK, SUMAC? _____
___Yes___No OTHER? _____
___Yes___No Has the participant had any serious illness or surgery within the past ten years?
Please list: _____
___Yes___No Does the participant have any condition that would prevent him/her from participating in any activities? Please list: _
_____
_____
___Yes___No Does the participant take any prescription medication? Please list: _____
_____
___Yes___No Are any drugs ineffective in treatment? _____
___Yes___No Is the participant diabetic? Medication? _____
___Yes___No Does the participant have any sight or hearing impairment? _____
___Yes___No Does the participant wear contact lenses? _____
___Yes___No Does the participant wear hearing aids? _____

Blood type:_____ Date of last Tetanus shot? _____

A current tetanus shot is required. After 7 years another tetanus shot is recommended.

Please indicate ANYTHING else that the leaders should know to help avoid or deal with any medical situation that might arise: