Troop #

TRAIL LIFE USA

An additional medical form is **required** for Trail Life USA activities or events that exceed 72 hours in duration or include high altitude or high-exertion activities. That High Adventure Medical form requires the examination by and the signature of a doctor or health care professional.

ADULT Member/Participant Health and Medical Record

Participant's Name | Date of birth (MM/DD/YYYY) | Age

Address

City | State | Zip | Phone #

Troop Leader

Emergency Contacts:

Name | Relationship

Name | Relationship

Home Phone # | Cell Phone #

Health/accident insurance information:

☐ Participant does not have health care coverage at this time (Please skip to next section – Physician Information)

☐ Participant has health care coverage as listed below

Health/accident insurance company | Policy #

Policy Holder | Group # | Effective Date

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD.

Physician Information:

Primary Care Physician | Phone #

Physician's address

Dentist's name | Phone #

Preferred Hospital

ALLERGIES	Please list all known allergies including those to medications, food and environment. If none known, please write "none known". Attach additional page to this form if needed.
Allergy to:	Normal reaction and management of the reaction:

Full Name: **Emergency Contact #:** **Troop #:**

HEALTH HISTORY		Do you currently have, or have you ever been treated for any of the following?			
Yes	**No**	**Condition**			**Explain**
☐	☐	Asthma	Last attack: (MM/YY)		
☐	☐	Diabetes	Last HbA1c: (Percentage)		
☐	☐	Hypertension (high blood pressure)			
☐	☐	Heart disease/heart attack/chest pain/heart murmur			
☐	☐	Stroke/TIA			
☐	☐	Lung/respiratory disease			
☐	☐	Ear/sinus problems			
☐	☐	Muscular/skeletal condition			
☐	☐	Psychiatric/psychological and emotional difficulties			
☐	☐	Behavioral/neurological disorders			
☐	☐	Bleeding disorders			
☐	☐	Fainting spells			
☐	☐	Thyroid disease			
☐	☐	Kidney disease			
☐	☐	Sickle cell disease			
☐	☐	Seizures	Last seizure: (MM/YY)		
☐	☐	Sleep disorders (e.g., sleep walking, sleep apnea)	Use CPAP?		
☐	☐	Abdominal/digestive problems			
☐	☐	Surgery	Last surgery: (MM/YY)		
☐	☐	Serious injury			
☐	☐	Excessive fatigue or shortness of breath with exercise			
☐	☐	Other			

Full Name: **Emergency Contact #:** **Troop #:**

IMMUNIZATIONS	The following immunizations are recommended. **Tetanus immunization is required and must have been received within the last 10 years**. For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY).

Yes	No	Immunization	Date of Immunization (MM/YY)	Please indicate if you have had the disease: Yes	No	Date of Disease (MM/YY)
☐	☐	Tetanus		☐	☐	
☐	☐	Pertussis		☐	☐	
☐	☐	Diphtheria		☐	☐	
☐	☐	Measles		☐	☐	
☐	☐	Mumps		☐	☐	
☐	☐	Rubella		☐	☐	
☐	☐	Polio		☐	☐	
☐	☐	Chicken Pox		☐	☐	
☐	☐	Hepatitis A		☐	☐	
☐	☐	Hepatitis B		☐	☐	
☐	☐	Meningitis		☐	☐	
☐	☐	Influenza		☐	☐	
☐	☐	Other (i.e., HIB)		☐	☐	
☐	☐	Exception to immunizations claimed (form required)				

MEDICATIONS	List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. If none, please write "None" below.

Medication	Strength	Frequency	Approximate Date Started	Reason

Administration of the above medications is approved by (if required by your state):

Adult participant signature

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You **SHOULD NOT STOP** taking any maintenance medication unless instructed to do so by your doctor.

Full Name: **Emergency Contact #:** **Troop #:**

I understand that, if any information I have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

This Health and Medical Record is correct and complete, as far as I know. I hereby give permission for Trail Life USA leadership to administer prescribed and noted over the counter medications in the event that I am personally unable to do so.

In case of emergency, I understand every effort will be made to contact my spouse or next of kin. In the event that they cannot be reached, I hereby give my permission to the licensed health-care provider selected by the Trail Life adult leader(s) to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for me, except as noted below. I agree to the release of records necessary for treatment.

Notes:

Participant's name

Participant's signature Date

This Health and Medical Record is valid for 12 calendar months.