Davidson Outdoors
PARTICIPANT MEDICAL HISTORY

NAME _____ PRONOUNS _____ DATE _____

HOME ADDRESS _____ GENDER _____

CITY _____ STATE _____ ZIP _____

YOUR CELL PHONE _____

Office Use Only

EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____

PRIMARY PHONE _____ ◯ CELL ◯ LAND LINE

SECONDARY PHONE _____ ◯ CELL ◯ LAND LINE

HEALTH INSURANCE INFORMATION

INSURANCE CO. _____ MEMBER/ POLICY # _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

YOUR CURRENT CONDITION

YOUR AGE _____ BIRTHDATE _____ HEIGHT _____ WEIGHT _____ lbs.

Overall Physical Condition Overall Health Swimming Ability:

SPECIAL DIETARY REQUIREMENTS:

DESCRIBE ANY CURRENT MEDICAL CONDITION OR ILLNESS:

ARE THERE ANY LIMITATIONS ON YOUR ACTIVITIES? If so, please describe:

LIST ALL MEDICATIONS YOU ARE TAKING & FOR WHAT CONDITION:

Last Name First Name Class

LIST ANY KNOWN ALLERGIES AND EXTENT OF REACTION (please write NKA - the abbreviation for "no known allergies,") :

Medications: _____

Insect Stings: _____

Food or other substance: _____

Do you carry medication to counteract a reaction? NO ◯ YES ◯ If Yes, please describe below.

PLEASE GIVE THE DATE OF YOUR LAST TETANUS BOOSTER: _____

Please check the appropriate column to indicate whether you have ever been diagnosed with the following:

	NO	YES	Dates & Descriptions
Anemia	☐	☐	
Allergic reactions	☐	☐	
Asthma	☐	☐	
Broken bones	☐	☐	
Diabetes or low blood sugar	☐	☐	
Dislocations	☐	☐	
Epilepsy or seizures	☐	☐	
Hearing problems	☐	☐	
Heart disease	☐	☐	
Hepatitis	☐	☐	
Hernia	☐	☐	
High blood pressure	☐	☐	
Vision problems	☐	☐	
Any condition not listed	☐	☐	

- I attest that the information I have provided is accurate and complete and that I am not withholding any pertinent medical information which might endanger my health or life, or endanger the lives of others.
- Additionally, I hereby consent to any emergency treatment, anesthesia, evacuation, and /or surgery which might become necessary while participating in Davidson Outdoors activities.
- I understand that program activities can be mentally and physically strenuous, and may take place in remote wilderness areas removed from medical facilities.

Signature of Participant _____ Date _____

Signature of Parent or Guardian _____ Date _____
(If Participant is under 18 years of age)

Submit Your Medform