

IN TOUCH WITH NATURE EDUCATION
CROSS-CULTURAL & ENVIRONMENTAL EDUCATION PROGRAMS

Medical Disclosure Form

Name

Date of Birth _____ Age _____ Height _____

Weight _____ Gender M or F

In case of Emergency, please contact:

Name _____

Relationship _____

Phone : () _____ day () _____ night

Doctor : _____

Doctor's Phone _____

Health Care #: _____

Do you wear glasses/contact lenses? _____

Can you swim? _____

Level of ability _____

Please mark any of the following illnesses or conditions that you have / have had:

Arthritis _____

Headaches _____

Toothaches _____

Menstrual Problems _____

Asthma _____

High Blood Pressure _____

Frostbite _____

Diabetes _____

Frequent Nosebleeds _____

Sleepwalking _____

Dizziness _____

Hepatitis _____

Heart Condition _____

Malaria _____

Earaches _____

Epilepsy _____

Stomach problems _____

Eye problems _____

Please Circle any of the following injuries that you have had, including description and the date it happened:

Back Pain

Concussion

Dislocation _____

Fracture _____

Joint Problems _____

Bad Sprains / Strains _____

Other _____

Are you under treatment for any illness or condition? _____

If so, please name and describe:

Are you currently taking any form of medication? _____

If so, please give name, dosage, frequency and side effects:

Do you have any disabilities? _____

If so, please describe them (include any fears and phobias):

Do you have any past injuries? _____

If so, please describe, including date and any effects:

Have you ever undergone surgery? _____

If so, please describe and give dates:

Have you been hospitalized in the past three years? _____

If so, please describe and give dates:

Is there any other information that we need to know to ensure your safest possible experience?

I, _____

(print name) declare that the information in this medical form is accurate and truthful. I recognize that providing inaccurate information may endanger myself / my child.

Signed: _____

Date: _____

Phone: _____

