

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

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Concussion

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Dislocation \_\_\_\_\_

Fracture \_\_\_\_\_

Joint Problems \_\_\_\_\_

Bad Sprains / Strains \_\_\_\_\_

Other \_\_\_\_\_

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Are you under treatment for any illness or condition? \_\_\_\_\_

If so, please name and describe:

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Are you currently taking any form of medication? \_\_\_\_\_

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

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Do you have any disabilities? \_\_\_\_\_

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

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Do you have any past injuries? \_\_\_\_\_

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

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Have you ever undergone surgery? \_\_\_\_\_

If so, please describe and give dates:

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Have you been hospitalized in the past three years? \_\_\_\_\_

If so, please describe and give dates:

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

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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: \_\_\_\_\_

