

Participant Health & Medical Information

**Please complete so event leaders and health providers can be aware of any medical treatment needs.
This must be completed by all participants ~ Please type or print legibly in ink!**

Name of Participant: _____

Does participant have: (if "yes" explain)

____Yes ____No Allergies? _____
____Yes ____No Heart conditions? _____
____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 five years?
Please list: _____
____Yes ____No Does the participant have any condition that would prevent him/her from participating
in any event 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: _____

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