

W.O.L.F.

Medical Information Form

Please Complete both sides of form

General Information

Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Business _____ Cellular _____
Other phone #1 _____ Other phone #2 _____ Other phone #3 _____
Male() Female() Height _____ Weight _____ Birth Date _____

Medical Information

Family Physician _____ Phone _____
Address _____
Person to be notified in case of emergency _____
H. Phone _____ B. Phone _____ Relationship _____
Date of last Tetanus booster _____
List medications to which you are allergic _____

List all other allergies _____

Have you ever been stung by a bee or a wasp? _____ When? _____ More than once? _____
Are you allergic to bee stings? _____ If yes, do you carry medications? _____
Name of medication _____ Nature of reaction _____

Medical History

List illnesses or conditions that you are now undergoing treatment and list all medications you are currently taking _____

If you have any of the following, state the year of occurrence and the location on your body:

Hernia _____ Fracture _____
Dislocation _____ Sprain or Strain _____

Name any injuries, illnesses, or disability not mentioned and year of occurrence:

If you have been hospitalized, list below:

Date _____ Name and location of hospital _____

Illness or Injury _____

Date _____ Name and location of hospital _____

Illness or Injury _____

Date _____ Name and location of hospital _____

Illness or Injury _____

Medical History Continued

If you now have, or have had any of the following symptoms or conditions, please circle "YES", underline and describe the problem. If not, circle "NO".

- a) YES NO Dizziness, Loss of Consciousness, or Recurrent Headaches
- b) YES NO Eye, Ear, Nose, Throat, Tonsils, or Sinus Symptoms
- c) YES NO Impairments of sight, Hearing, or Speech
- d) YES NO Chronic Cough, Bronchitis or Asthma, Coughing up of Blood, Close Contact with Tuberculosis
- e) YES NO Chest Pain, Shortness of Breath, Palpitation, Swelling of Ankles, Heart Murmur, Heart Disease, High and Low Blood Pressure
- f) YES NO Reaction to Bee Stings
- g) YES NO Sensitivities/Allergies to: Horse Serum (Tetanus Antitoxin), Sulfa, Penicillin, or any other drug
- h) YES NO Symptoms relating to the Gastro Intestinal Tract (ie: Diarrhea, recurring abdominal pain, passing of blood, ulcer of stomach or duodenum)
- i) YES NO Severe Menstrual Cramps or Menstrual problems, Currently Pregnant
- j) YES NO Albumin, Sugar or blood in urine; Kidney Stone, Frequency in Urinating, Bed Wetting, or other Urinary Difficulties
- k) YES NO Muscle, Joint, Knee or Back Pain, Bursitis, Arthritis, Sciatica
- l) YES NO Benign or Malignant Growth or Tumor
- m) YES NO History of Diabetes, Thyroid Imbalance, Hypoglycemia
- n) YES NO Episodes of Depression, Anxiety, Hysteria, Nervousness
- o) YES NO Special Dietary Restrictions, ie: Diabetic, Low Cholesterol, Vegetarian, etc.

Give details to all of the questions above to which you circled "YES"

Insurance

We do not provide sickness or accident insurance for participants. Therefore, it is each participant's responsibility to be covered by his or her own hospitalization policy.

Does any hospitalization or medical care policy cover you? _____

If yes, indicate name of insurance company issuing policy _____

Policy or Certificate Number _____

Signature (If participant is under 18 years of age, parent or guardian **MUST** sign)

In the event of an accident or emergency, I grant permission for any medical care, operations, and/or anesthesia that might become necessary as deemed by emergency medical personnel and WOLF staff and directors.

Signature _____ Date _____

Print Name _____ Relationship _____