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_____Relationship_____
Home Phone_____ Cell Phone_____
Date of last Tetanus booster_____
List of all allergies_____
_____

☐ **INITIAL**

I am not currently experiencing symptoms of any illness and will not attend the trip if experiencing symptoms of any illness

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_____