Texas A&M-Commerce University
Outdoor Adventure
Medical Information Form

Please return form to: Group Leader: *The information on this form will help the facilitator(s) leading the group to ensure that they are aware and prepared to respond appropriately, if the need arises. Information requested on this form will be kept confidential.*

Name of Group: _____
Date(s) & Time-frames: _____

Participant's Name: _____ Birth Date: _____ Weight: _____

Address: _____ Home #: _____ Work #: _____

Organization: _____ Gender: M or F

Emergency Contact Person's Name: _____ Relationship to Participant: _____

In case of emergency, contact #: _____

Participant's Medical History:

1.) Are you presently under a doctor's care? **Yes or No** *If yes, please describe condition*: _____

_____

Physician's Name: _____ Phone #: _____

2.) **Do you have? Yes or No**

A. Asthma: _____
B. History of heart disease, heart problems, and/or high blood pressure: _____
C. Any type of seizure disorder: _____
D. History of anaphylaxis: _____
E. Diabetes: _____
F. Any limiting physical disabilities or handicap (temporary or permanent): _____

If yes, please give us additional information: _____

_____

_____

_____

3.) Are you presently on medication? **Yes or *No*** *If yes, please list the medication(s) and the reason for its use:*

_____

4.) I certify that the following health/accident insurance company covers the participant.

Company's Name: _____ Policy #: _____