



Outdoor ESCAPES New Hampshire, LLC
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MEDICAL FORM
To be completed for each participant

HEALTH INFORMATION

Your guide will use the following information in case you become ill or injured. It will be kept confidential and will be reviewed by a physician who may contact you for additional information. The info. doesn't necessarily influence your acceptance into this program.

Name: _____ Age: _____ Weight: _____ Height: _____ Sex: _____
 Address: _____ City: _____
 State/Province: _____ Zip/Postal Code _____
 Daytime Phone _____ Nighttime Phone _____

Do you have any sensory or physical limitations? _____ If so, list and state how they affect you:

Do you have any learning or emotional limitations? (This includes fear of heights, dogs, water, etc.) _____ They are:

What are the medications, physical aids, or strategies that your condition requires?

Are you currently taking any over-the-counter or prescription medications? _____
 If yes, please list them and describe what they are for:

Are you currently under the care of a medical specialist? _____ If yes, for what conditions?

Do you have any food allergies or dietary restrictions? _____ If yes, please describe:

Do you have any environmental or medicinal allergies? _____ If yes, please describe:

Are you bringing an Epi Pen with you on the tour? _____ If so, who will be carrying it and where will it be stored?

Please list any pertinent experience you have had. _____

Please describe what physical exercise you regularly take part in. How often? _____

Have you had a tetanus shot in the last 4 years? Yes No Have you been immunized against Hepatitis B? Yes No
 Have you received all childhood disease immunizations? Yes No When was your last TB test? _____

Do you have any of the following?
 _____ Hemophilia _____ Lung disease, Asthma _____ Allergy to bee stings _____ Knee condition
 _____ Diabetes _____ Ulcer or other GI disorder _____ Any other allergies _____ Back condition
 _____ Hernia/ruptures _____ Heart defect/disease _____ Seizures or other CNS disorder _____ Arthritis

If you answered yes to any of the above, please describe the exact diagnosis and treatment:

EMERGENCY INFORMATION

Participant's Name: _____
 Participant's health insurance company: _____ Phone # _____
 Policy # _____ Group # _____
 Name of Policyholder _____
 Relationship of Policyholder to Participant _____

Physician: _____ Phone # _____

Relative or close friend to be notified in case of emergency:
 Name: _____
 City _____ State _____ Zip _____
 Phone (day) _____ (evening) _____