



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

**HEALTH INFORMATION**

Date & Name of Adventure: \_\_\_\_\_

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) \_\_\_\_\_