



## Medical History

Mark any and all medical conditions you have or have had in the past.

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| <input type="checkbox"/> Bleeding or Clotting Problems    | <input type="checkbox"/> Dislocations, Fractures, Bone Problems |
| <input type="checkbox"/> Heart or Blood Pressure Problems | <input type="checkbox"/> Mental Health Problems                 |
| <input type="checkbox"/> Physical Disability              | <input type="checkbox"/> Respiratory Problems or Asthma         |
| <input type="checkbox"/> Diabetes                         | <input type="checkbox"/> Eating Disorders                       |
| <input type="checkbox"/> Joint Problems                   | <input type="checkbox"/> Neck, Spine or Back Problems           |
| <input type="checkbox"/> Pregnancy                        | <input type="checkbox"/> Seizures or Epilepsy                   |

Describe all medical conditions (listed above or otherwise).

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Describe all recent surgeries, injuries and illnesses.

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## Allergies

List all known allergies. Include food, medication, insect, topical, and all other allergies you may have. If applicable, describe the symptoms you experience when exposed to each allergen and when you last had a reaction.

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## Medications

List all prescription and non-prescription medications you take. Indicate why you take each, the dosage and frequency.

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## Emergency Contacts

List two people (not on the trip) who could be contacted in the case of a medical emergency.

Name	Phone Number	Alternate Phone Number	Relationship