

## **Medical Release Form**

Name:		Emergency Contact:						
Address:		Emergency Contact Home Phone:						
Home Phone:		Emergency Contact Cell Phone:						
Cell Phone:		Physician:						
DOB:		Physician Phone:						
<u>Insurance Information</u>								
Do you have insurance?		Policy Number:						
Name of insured:		Insurance Phone:						
Insurance Company:		Insurance Address						
Medications								
Medication	How much/often	For	Current Side Effects					
Medical Allergies								
Allergy		Reaction						
I approve of emergency care for myself or the above minor under the direction of the event leader or consulting doctor, if I am unable to make my wishes known. (Cross out the last statement if you do not wish to grant medical consent). I have read, understand and agree to the above listed statement and do sign this agreement of my own free will. I hereby release Cornerstone Recovery, Inc, its employees and volunteers from any and all liability with relationship to the above mentioned person's participation in the 2012 Grand Canyon Trip. By signing this form I acknowledge that my son/daughter is physically and mentally able to participate in all aspects of this program. This release includes consent for the transportation to and from the site of the activities as well as the activities themselves.								

Signature of Participant (if 18 or older) if under 18, signature of parent/guardian



## **Medical History**

Do you have, or have you had, any of the following conditions? Please check all boxes that apply. □01.Heart disease of any kind □ 20. Arthritis ☐ 39. Eating disorder □02.Heart attack  $\square$ 21. Joint problems □ 40. Psychiatric/Emotional problems □03. Heart Murmur  $\square$  22. Broken bones □41. Difficulty urinating □42. Kidney problems □04. Irregular heart beat  $\square$  23. Neck or back problems  $\square$ 05. Heart palpitations □43. Bleeding disorders ☐ 24. Diabetes  $\square$ 06. Chest pain or pressure □ 25. Hypoglycemia □ 44. Blood disorder/Anemia  $\square$ 07. Circulation problems  $\square$  26. Thyroid problems □45. Sickle cell trait or disease  $\square$  27. Unexplained weight loss □46. HIV/AIDS □ 08. High blood pressure  $\square$ 09. Unexplained sweating □ 28. Obesity ☐ 47. Medical equipment/devices  $\square$  10. Shortness of breath □ 29. Endocrine/gland problems □48. Skin problems □11. Asthma □ 30. Vision Impairment  $\square$ 49. Special dietary needs □ 12. Chronic cough □31. Cancer  $\square$  50. Special physical requirements □ 13. Tuberculosis (TB) ☐ 32. Headaches □ 51. Bipolar Disorder □ 14. Frequent Lung Infections ☐ 33. Seizure disorder ☐ 52. Mood Disorder □ 15. Ulcer  $\square$  34. Seizure within last year ☐ 53. Post-Traumatic Stress Disorder ☐ 16. Heartburn □ 35. Significant head injury ☐ 54. Major Depression  $\square$  17. Intestinal problems □55. Other ☐ 36. Frequent dizziness □ 18. Active hepatitis □ 37. Frequent fainting ☐ 19. History of Hepatitis □38. Learning disorder IF YOU CHECKED ANY OF THE ABOVE ITEMS PLEASE EXPLAIN IN THE SPACE PROVIDED BELOW.



## TO BE COMPLETED BY PHYSICIAN

Participant's Last Name		First Name					Date of Birth		
			Date of	,	Height	Weight	Pulse &		
			Birth		Height	weight	BP		
Patient Info			Dirtii			Dr			
1 dient into	int inio								
Immunizations	DPT/TD	MMR 2(required)		Polio		Hep I	Hep B		
Date of last									
Medical History									
•									
Last Tetanus Shot									
Does Participant have any known clinical abnormalities or medical conditions that would impair or limit their ability to									
participate in outdoor wilderness activities that include hiking, back packing, rock climbing, exposure to natural									
elements?									
Does the Participant take any prescription Medication? If so, please list dosage, name and reason for medication									
<del></del>									
PHYSICIAN'S INFORMATION (Please Print)									
Name	()								
Address									
Telephone									
Date									
					_				

\_M.D

Physician's Signature