CRAWDADDY OUTDOORS LC

CrawDaddy Outdoors LC does not offer or provide insurance for activities/trips. You are advised to acquire your own medical insurance.

If you do not have insurance, initial this line stating that you do not have health insurance and are aware that CrawDaddy Outdoors LC does not carry any health insurance for you. _____ _____
Initial Date

Annual Health and Medical Record

GENERAL INFORMATION

Name_____ Date of birth_____ Age_____ ◯ Male ◯ Female

Address_____

City_____State_____ Zip_____ Phone Number_____

Social Security No. (Optional)_____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE' ABOVE.

In case of emergency, notify

Name_____ Relationship_____

Address_____

Home phone_____Business phone_____ Mobile Phone_____

Alternate contact name_____ Alternate phone_____

HEALTH HISTORY

Do you currently have, or have you ever been treated for any of the following?

Yes	No	Condition	Explain
◯	◯	**Asthma** **Last attack**: (MM/YY)	
◯	◯	**Diabetes** **Last HbA1c:** (percentage)	
◯	◯	**Hypertension (High Blood Pressure)**	
◯	◯	**Heart disease/heart attack/chest pain/heart murmur**	
◯	◯	**Stroke/TIA**	
◯	◯	**Lung/respiratory disease**	
◯	◯	**Ear/sinus problems**	
◯	◯	**Psychiatric/ psychological and emotional difficulties**	
◯	◯	**Behavior/neurological disorders**	
◯	◯	**Fainting spells**	
◯	◯	**Seizures** **Last seizure:**	
◯	◯	**Sleep disorders (e.g. sleep apnea)**	Use CPAP: ◯ Yes ◯ No
◯	◯	**Abdominal/digestive problems**	
◯	◯	**Excessive fatigue or shortness of breath with exercise**	
◯	◯	**Knees, joint or back problems**	
◯	◯	**Allergies including medications**	
◯	◯	**Vision**	
◯	◯	**Other**	

MEDICATIONS List medications currently use. (If additional space is needed, please photocopy this part of the heath form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

No Medications ◯

Medication: _____ Strength:_____ Frequency: _____ Appropriate date started: _____ Reason for medication: _____	Medication: _____ Strength:_____ Frequency: _____ Appropriate date started: _____ Reason for medication: _____
Medication: _____ Strength:_____ Frequency: _____ Appropriate date started: _____ Reason for medication: _____	Medication: _____ Strength:_____ Frequency: _____ Appropriate date started: _____ Reason for medication: _____

I have read and understand this form's contents completely and have answered the above questions accurately.

I believe that I/participant am in good physical condition and that I/participant can participate fully in trip activities.

The staff of Crawdaddy Outdoors has my authorization to review and retain this form as protected health information for the purposes of the above program. The staff of Crawdaddy Outdoors has my permission to seek and or administer emergency care for the participant in the event that the participant or guardian cannot respond at the time of emergency and has authorization to provide this form to health care personnel for the purposes of the participant's emergency treatment in that event. I understand that Crawdaddy Outdoors is not responsible for any charges for such health care services provided to the participant.

I understand that I have the right to revoke, in writing, this authorization at any time; however, this authorization will automatically expire at the end of the above program. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and or disclose the participants protected health information have acted in reliance upon this authorization. Further, I understand that if a participant's health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

Date: _____ Signature of participant: _____

Date: _____ Signature of parent/guardian:_____