CONFIDENTIAL MEDICAL HISTORY
Stone Harbor Wilderness Supply

This form must be completed and signed before participation in Stone Harbor Wilderness Supply programs. To be completed by parent or legal guardian if participant is under legal age.

Participant's Name _____ Tour/Instruction _____

Address _____ City_____ State_____ Zip_____

Day Phone _____ Evening Phone _____Cell Phone _____

Sex (circle one) M F Age _____ Birthdate _____

Height_____ Weight_____

E-Mail _____

Person to be notified in case of illness or injury _____

Address _____ City_____ State_____ Zip_____

Relationship _____

Day Phone _____ Evening Phone _____Cell Phone _____

Health History - check those items that apply:

- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Bronchitis
- ☐ Constipation
- ☐ Contact Lenses
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Fainting
- ☐ Frequent Sore Throat
- ☐ Hearing Impairment
- ☐ Heart Trouble
- ☐ Seizures
- ☐ Serious Ivy/Oak Poisoning
- ☐ Sleep Walking
- ☐ Sunstroke/Sensitivity
- ☐ Vision Impairment

Please explain any checked items:

Medications Currently Taken:

Directions: (How much, when given, etc.)

Reason for Medication: (Please be specific)

Tetanus Immunization Date _____
**** Very Important:** Must be within 10 years of participation

Any physical limitations or braces worn (give details of care required)

Operations or serious injuries (give details)

Special food limitations or requirements

Allergic Reaction: Insect/Bee Stings _____Penicillin _____ Other Drugs

Food, plants, or animals, which cause reaction

Reaction and treatment if exposed

Medical Insurance Company: Policy/Certificate Number:

Address of Insurance

Company_____

Circle here if no coverage

I hereby state that this medical information is accurate.

Name: _____

Signature: _____ Date:_____

April 2013