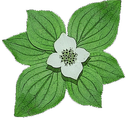

EASTERN OUTDOOR EXPERIENCES
Participant Health History

Participant Information

Name: ______________________________________Cell Phone: _________________________

Address: ____

City: ____ State: _______ Zip: ___________

Date of Birth: ___________________ Age: __________ Email: ____________________________

Gender: □ Male □ Female

Emergency Contact Information

Contact Name: ____ Relationship: ____________

Cell Phone: ___________________________________ Home Phone: ______________________

Health History

1. List all known allergies (Medicine, Environmental, Food allergies): _________________

   ____

   Do you carry an Epi Pen or other medication? ___________________________________

2. Do you have asthma? ____

   When did you last use an inhaler? ____

3. Do you have diabetes? ____

   If yes, do you require insulin or other medication? ______________________________

4. Do you have a history of seizures? ____

   If yes, do you currently take any medication? ___________________________________

5. Do you have heart disease or any other heart conditions? ________________________

   If yes, please explain: ____

6. Have you ever had any musculoskeletal injuries/surgeries? _______________________

   If yes, please explain: ____

7. Do you have any issues with your vision or hearing? _____________________________

   If yes, please explain: ____

8. Have you ever had a heat related injury (heat stroke or heat exhaustion)? ___________

   If yes, please explain: ____

9. Have you ever had a cold weather injury (hypothermia, frostbite/frostnip)? _________

   If yes, please explain: ____

10. Are you currently taking any medications for medical issues listed above? ___________

    If yes, please explain: ____

11. Do you have medical insurance? ____

    If yes, who is your carrier? ____