Trail Life
Adventure › Character › Leadership

An additional medical form is **required** for Trail Life USA activities or events that exceed 72 hours in duration or include high altitude or high-exertion activities. That High Adventure Medical form requires the examination by and the signature of a doctor or health care professional.

# ADULT Health and Medical Form

Participant's Name _____ Date of birth _____ (MM/DD/YYYY) Age _____

Address _____

City _____ State _____ Zip _____ Phone # _____

Troop Leader Matt Poage Troop# TX-0521

Emergency Contacts:

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

Health/accident insurance information:

☐ Member does not have health care coverage at this time (Please skip to next section – Physician Information)

☐ Member has health care coverage as listed below

Health/accident insurance company # 1 _____ Policy # _____

Policy Holder _____ Group # _____ Effective Date _____

Health/accident insurance company # 2 _____ Policy # _____

Policy Holder _____ Group # _____ Effective Date _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD.

Physician Information:

Primary Care Physician _____ Phone # _____

Physician's address _____

Dentist's name _____ Phone # _____

Preferred Hospital _____

| ALLERGIES | Please list all known allergies including those to any medications, food and environment. If none are known, please write "none known". Attach additional page to this form if needed. |
|---|---|
| Allergy to: | Normal reaction and management of the reaction: |
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| 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 | | | | |
| ☐ | ☐ | Muscular/skeletal condition | | | | |
| ☐ | ☐ | Psychiatric/psychological and emotional difficulties | | | | |
| ☐ | ☐ | Behavioral/neurological disorders | | | | |
| ☐ | ☐ | Bleeding disorders | | | | |
| ☐ | ☐ | Fainting spells | | | | |
| ☐ | ☐ | Thyroid disease | | | | |
| ☐ | ☐ | Kidney disease | | | | |
| ☐ | ☐ | Sickle cell disease | | | | |
| ☐ | ☐ | Seizures | Last seizure: (MM/YY) | | | |
| ☐ | ☐ | Sleep disorders (e.g., sleep walking, sleep apnea) | | Use CPAP? | ☐ | |
| ☐ | ☐ | Abdominal/digestive problems | | | | |

| | | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ | Surgery | Last surgery: (MM/YY) | | |
| ☐ | ☐ | Serious injury | | | |
| ☐ | ☐ | Excessive fatigue or shortness of breath with exercise | | | |
| ☐ | ☐ | Other | | | |

| IMMUNIZATIONS | The following immunizations are recommended. For each item, indicate if you have been immunized, the date of the immunization (MM/YY), if you have had the disease, and the date (MM/YY). |
|---|---|

| Yes | No | Immunization | Date of Immunization (MM/YY) | Please indicate if you have had the disease: Yes | Please indicate if you have had the disease: No | Date of Disease (MM/YY) |
|---|---|---|---|---|---|---|
| ☐ | ☐ | Tetanus | | ☐ | ☐ | |
| ☐ | ☐ | Pertussis | | ☐ | ☐ | |
| ☐ | ☐ | Diphtheria | | ☐ | ☐ | |
| ☐ | ☐ | Measles | | ☐ | ☐ | |
| ☐ | ☐ | Mumps | | ☐ | ☐ | |
| ☐ | ☐ | Rubella | | ☐ | ☐ | |
| ☐ | ☐ | Polio | | ☐ | ☐ | |
| ☐ | ☐ | Chicken Pox | | ☐ | ☐ | |
| ☐ | ☐ | Hepatitis A | | ☐ | ☐ | |
| ☐ | ☐ | Hepatitis B | | ☐ | ☐ | |
| ☐ | ☐ | Meningitis | | ☐ | ☐ | |
| ☐ | ☐ | Influenza | | ☐ | ☐ | |
| ☐ | ☐ | Other (i.e., HIB) | | ☐ | ☐ | |

**Full Name:** _____ **Emergency Contact #:** _____

| MEDICATIONS | List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only. If none, please write "None" below. | | | |
|---|---|---|---|---|
| Medication | Strength | Frequency | Approximate Date Started | Reason |
| | | | | |
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Administration of the above medications and such over-the-counter medications as may be deemed necessary for the health and safety of Participant is approved by (if required by your state):

_____ _____

Adult Participant's Name Adult Participant's Signature

Bring enough medications in sufficient quantities and in the original containers. Make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication unless instructed to do so by your doctor.

I do hereby attest that the participant is able to self-administer the above listed emergency use medications in case of emergency.

_____ _____

**Adult participant's name** **Adult participant's signature**

This Weekend Health and Medical Record is valid for 12 calendar months.