Adult Health and Medical Form

Note: 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. The High Adventure Medical Form requires the examination by and the signature of a doctor or health care professional.

PARTICIPANT INFORMATION

Participant Name _____ **Date of Birth** _____ **Age** _____

Phone _____ **Street Address** _____

City _____ **State** _____ **Zip** _____

Troop Leader _____ **Troop #** _____

EMERGENCY CONTACTS

Name _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____

Name _____ **Relationship** _____

Home Phone _____ **Cell Phone** _____

INSURANCE INFORMATION

☐ Member does not have health care coverage at this time. Continue to next section.

☐ Member has health care coverage as listed below.

Insurance Company #1 _____ **Policy #** _____

Policy Holder _____ **Group #** _____ **Effective Date** _____

Insurance Company #1 _____ **Policy #** _____

Policy Holder _____ **Group #** _____ **Effective Date** _____

Please include a copy of both sides of your insurance card when submitting this form.

PHYSICIAN INFORMATION

Primary Care Physician _____ **Phone** _____

Physician Address, City, State, Zip _____

Dentist _____ **Phone** _____

Dentist Address, City, State, Zip _____

Preferred Hospital _____

ALLERGIES

Please list all known allergies, including those to any medication, food, and environment. If none are known, please write "none known." Include a description of the normal reaction and the best management of the reaction. Attach an additional page with this form as needed.

Allergy	Reaction/Management

HEALTH HISTORY

Please complete the following information regarding your 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 *(%)*: 0%	
☐	☐	Hypertension *(High Blood Pressure)*		
☐	☐	Heart Disease, Heart Attack, Check Pain, Murmur		
☐	☐	Stroke/TIA		
☐	☐	Lung/Respiratory Disease		
☐	☐	Ear/Sinus Problems		
☐	☐	Muscular/Skeletal Condition		
☐	☐	Psychiatric/Psychological/Emotional Difficulties		
☐	☐	Behavioral/Neurological Disorders		

Yes	No	Condition		Explain
☐	☐	Bleeding Disorders		
☐	☐	Fainting Spells		
☐	☐	Thyroid Disease		
☐	☐	Kidney Disease		
☐	☐	Sickle Cell Disease		
☐	☐	Seizures	Last Seizure *(mm/yy)*:	
☐	☐	Sleep Disorders	Use CPAP? ☐	
☐	☐	Abdominal/Digestive Problems		
☐	☐	Surgery	Last Surgery *(mm/yy)*:	
☐	☐	Serious Injury		
☐	☐	Excessive Fatigue/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 of the disease (MM/YY).

Immunized?		Immunization	Date of Immunization	Had Diseasse?		Date of Disease
Yes	No			Yes	No	
☐	☐	Tetanus		☐	☐	
☐	☐	Pertussis		☐	☐	
☐	☐	Diphtheria		☐	☐	
☐	☐	Measles		☐	☐	
☐	☐	Mumps		☐	☐	
☐	☐	Rubella		☐	☐	
☐	☐	Polio		☐	☐	

☐	☐	Chicken Pox		☐	☐	
☐	☐	Hepatitis A		☐	☐	
☐	☐	Hepatitis B		☐	☐	
☐	☐	Meningitis		☐	☐	
☐	☐	Influenza		☐	☐	
☐	☐	Other (i.e., HIB)		☐	☐	

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	Approx Start Date	Reason

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 Name *Adult Participant 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 Signature *Date*

_____

Adult Participant Name

This Adult Health and Medical Form is valid for 12 calendar months.