

Seguin Outdoor Learning Center Health and Medical History Form

(This information will be treated with the strictest confidentiality)

GENERAL INFORMATION:

Name: _____ Gender: M F Age: _____ Program Date: _____
Local address: _____ City/State: _____
Local phone: () _____ Zip: _____
Work or cell phone: _____ E-Mail Address: _____

EMERGENCY INFORMATION:

In case of emergency contact: _____ Relationship: _____
Home Phone: () _____ Work Phone: () _____ Cell Phone: () _____
Address: _____ City/State: _____ Zip: _____
Your Health Insurance Company: _____ Policy #: _____
Your Doctor's Name: _____ Doctor's Phone: () _____

MEDICAL HISTORY:

Do you have any allergies? _____ If so, what? _____
Are you currently taking medication(s)? _____ If so, what and why? _____

Recent or recurring injuries, recent surgeries, and/or disabilities: _____

	<u>Circle</u>			<u>Circle</u>	
• Pregnant	yes	no	• Seizures	yes	no
• Diabetes	yes	no	• Asthma	yes	no
• High blood pressure	yes	no	• Heart attack	yes	no
• Chest pains	yes	no	• Heart disease	yes	no
• Shortness of breath	yes	no	• Family history of heart disease	yes	no
• Stroke	yes	no	• Episodes of anxiety or depression	yes	no

Current level of fitness: fewer than three 20-minute aerobic activities per week.
 three or more 20-minute aerobic activities per week.

Any activity limitations or other conditions you want us to know about: _____

I affirm the information above is accurate and true to the best of my knowledge and that I have not withheld any information that would result in a health risk while participating on the challenge course.

Signature _____ Date _____
(Participant or Parent/Guardian if under 18)