General Medical Information Form

Please print out, complete this form and return to staff before project start date.

Special Note: This information alerts our staff to any special medical conditions you may have, rather than learning about them in a crisis. In the event of serious injury or illness, this form provides emergency medical personnel with a useful medical history. For your safety, we may contact you to discuss how your medical history may affect participation in Ranch activities. The information on this form will be kept confidential and will be on file as long as you remain in our program.

Name:	Gender: Male Female
Address:	
City: State: Zip:	
Home Phone: (Parent's) Work: (Parent's) Cell:	
Date of Birth:	E-mail:
Height: Weight:	Blood Pressure: Resting Pulse:
Emergency Contact: Relationship: Contact's Home Phone: Work: Cell:	

Medical Insurance Information

Company Name:	Policy Number:
Allergies: *List any medicines, foods, animals, insect bites and stings, and environment (dust, pollen, etc.). that apply:*	
Allergy Reaction Medication Required (*if any*):	

Medical History

Please list all prescription, over-the-counter, and natural medications you are taking. (*Use a separate sheet if necessary.)*

Medications: *(Please list names, dosages, side effects, reason for taking, etc.)*

Recent serious illness? *(If yes, please explain.)*

Other medical events? *(Please list any recent accidents, operations, hospitalizations, exposure to infectious diseases, etc.?)*

Do you have asthma? Yes No	Diabetes? Yes No
A history of high blood pressure? Yes No	Eye or vision problems? Yes No
Do you wear glasses or contact? Yes No	Any hearing problems? Yes No
Bone, joint, or muscle problems? Yes No	Have you ever had a seizure? Yes No

Any other medical issues that might affect your participation? Yes No
If yes, please explain:

If you have no physical limitations that would keep you from participating in physical activities, please sign here (parent or guardian for 18 and under):

Tetanus: It is strongly advised that you are inoculated against this fatal disease and you obtain a booster every 10 years. Date of your most recent tetanus shot or booster: / /

Physical Examination

Date of most recent physical: / / Physician's name:
Address: Phone Number:

Physician's signature:

Adult or Parent/Guardian signature:

Date: / /