

Riekes Center Medical Information Form

Name: _____ Gender _____

Birth date: ____/____/____ Age _____ Height _____ Weight _____

Address: _____ City _____

State _____ Zip _____ Phone _____ Cell _____

If under 18 years of age list Name of Parent / Legal Guardian(s) _____

If address is different than above please list: _____

Phone: Work _____ Cell _____ Other _____

Name two alternates (relatives/friends) who may be contacted in case you can not be reached in an emergency;

Name _____ Name _____

Relationship _____ Relationship _____

Address _____ Address _____

Phone _____ Phone _____

Family Physician _____ Phone _____

Medical Insurance Carrier: _____

Policy Number _____ Phone _____

Type of Coverage _____

Medical History:

1. Chronic or long term illnesses: No [] Yes [] If yes, specify: _____

2. Operations or serious injuries: No [] Yes [] If yes, specify: _____

3. Do you have any dietary restriction? (Vegetarian, lactose intolerant, etc.) No [] Yes [] If yes, specify:

4. Do you have any allergies? List food, drug, plant, animal insect or other allergies. No [] Yes [] If yes, specify

<u>Allergy</u>	<u>Reaction</u>	<u>Medications</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Note: If you have an anaphylactic allergic reaction you must bring your own prescription medication i.e. EpiPen.

5. Give date of last immunization for: Tetanus/TD _____ MMR _____ Other _____

**Note: A tetanus within 10 years is recommended.

6. Are you taking any medications? No [] Yes [] If yes, specify

Applicant's Name _____

<i>Medication</i>	<i>Condition</i>	<i>Dosage (amount/frequency)</i>	<i>Side Effects</i>

7. Describe your current level of physical activity? (very active, active, sedentary)

8. Do you wear: contact lenses [] eyeglasses [] hearing aids [] special auxiliary aids []

**Note: If you wear corrective lenses please bring extra contact lenses or glasses to lengthy or remote programs.

9. Have you had any recent injuries, illnesses, hospitalizations, or surgeries? No [] Yes [] If yes, specify

10. What is your level of swimming ability? [] non-swimmer [] beginner [] intermediate [] advanced

11. Do you have any medical conditions? No [] Yes [] Please complete all of the following questions.

seizure/epilepsy	YES	NO	back problems	YES	NO
diabetes	YES	NO	bladder/ kidney infections	YES	NO
high / low blood sugar	YES	NO	ulcers	YES	NO
asthma	YES	NO	knee/ankle	YES	NO
heart problems	YES	NO	hernia	YES	NO
high blood pressure	YES	NO	sprains/joint problems	YES	NO
respiratory problems	YES	NO	emotional problems	YES	NO
menstrual difficulties	YES	NO	psychological problems	YES	NO
shortness of breath	YES	NO	activity restrictions	YES	NO
recent surgery	YES	NO	other medical problems	YES	NO

If YES, please give a detailed description (symptoms, treatment, and dates). Use separate sheet if necessary.

Medical Authorization

I verify that the above information is complete and accurate. I understand measures will be taken to safeguard the health and safety of all participants; however, in the event of need I hereby grant permission of the Riekes Center or its authorized representatives to arrange for such medical care that I (or my child) may require. This includes minor medical care in the field by Riekes Center staff members, which may include the administration of over the counter medications if needed. I also authorize Riekes Center staff to administer prescription medications provided by the parent or guardian as needed by the child/ward during the program. In the event of serious injury or illness or the need for hospitalization and/or surgery, Riekes Center will use all reasonable efforts to contact the parent, guardian and/or people listed as emergency contacts. In the event contacts cannot be reached in an emergency I authorize the Riekes Center in arranging emergency treatment that may be necessary. I am aware that the Riekes Center assumes no liability for the costs or provision of evacuation and medical care in the event that care is needed during or after this program. If I (or my child) have a medical condition, I (or my child) have been seen by a physician who is aware of my present condition, health history, and trip details and recommends that I (or my child) be able to fully participate.

Participant Full Name _____

Participant Signature _____ Date _____

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