TRAIL LIFE USA

ADULT Weekend Health and Medical Record

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.

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

Address _____

City _____ State _____ Zip _____ Phone # _____

Troop Leader _____ Troop# _____

Emergency Contacts:

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

Name _____ Relationship _____

Home Phone # _____ Cell Phone # _____

Health/accident insurance information:

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

☐ Participant has health care coverage as listed below

Health/accident insurance company _____ 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 medications, food and environment. If none known, please write "none known". Attach additional page to this form if needed.
Allergy to:	Normal reaction and management of the reaction:

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

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 HbAlc: (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				

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

IMMUNIZATIONS	The following immunizations are recommended. **Tetanus immunization is required and must have been received within the last 10 years**. 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	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)				
		Exception to immunizations claimed (form required)				

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

Administration of the above medications is approved by (if required by your state):

_____

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.

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

I understand that, if any information I have provided is found to be inaccurate, it may limit and/or eliminate the opportunity for participation in any event or activity.

This Health and Medical Record is correct and complete, as far as I know. I hereby give permission for Trail Life USA leadership to administer prescribed and noted over the counter medications in the event that I am personally unable to do so.

In case of emergency, I understand every effort will be made to contact my spouse or next of kin. In the event that they cannot be reached, I hereby give my permission to the licensed health-care provider selected by the Trail Life adult leader(s) to secure proper treatment, including related transportation, hospitalization, anesthesia, surgery, or injections of medication for me, except as noted below. I agree to the release of records necessary for treatment.

Notes:

_____

_____

_____

Participant's name _____

Participant's signature _____ Date _____

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