

Medical History/Treatment – Cornerstone Recovery Summer 2008

Name _____ Birthdate _____ Male ___ Female ___

Address _____ City _____ State _____ Zip _____

MEDICAL HISTORY (PLEASE ATTACH A COPY OF FRONT/BACK of INSURANCE CARD)

YES NO

1. Do you have any physical complaints or chronic illness at this time?
If yes, what: _____

2. Have you had injuries in the past (i.e., back, knee, shoulder, elbow, etc.)?
If yes, what: _____

3. Are you currently under the care of a physician or practitioner of any sort?
If yes, why: _____

4. Are you taking medicines of any type?
If yes, what: _____

5. Are you on a special diet?
If yes, what kind: _____

6. Do you have or have you ever had:
a. Diabetes? If yes, are you taking insulin? How much? _____

b. Seizures?

c. Asthma?

d. Allergies? To what: _____

* e. Are you allergic to bee stings? Type of reaction: _____

*If yes, (please carry your medication with you on the course)

f. Any other medical information? _____

7. Emergency Contact Person: _____
Phone Number: _____

Name of Physician: _____

Address: _____ Phone: _____

Name of Insurance: _____ Group & ID Number: _____

I approve of emergency care for myself or the above minor under the direction of the event leader or consulting doctor, if I am unable to make my wishes known. (Cross out the last statement if you do not wish to grant medical consent). I have read, understand and agree to the above listed statement and do sign this agreement of my own free will. I hereby release Cornerstone Recovery, Inc, its employees and volunteers from any and all liability with relationship to the above mentioned person's participation in the Cornerstone Recovery 2008 Summer Wilderness Trip. By signing this form I acknowledge that my son/daughter is physically and mentally able to participate in all aspects of this program. This release includes consent for the transportation to and from the site of the activities as well as the activities themselves.

Signature of Participant (if 18 or older)
if under 18, signature of parent/guardian

Participant's Last Name	First Name	Date of Birth

Patient Info	Date of Birth	Height	Weight	Pulse & BP

Immunizations Date of last	DPT/TD	MMR 2(reqd)	Polio	Hep B

Medical History

Last Tetnus Shot _____

Does Participant have any known clinical abnormalities or medical conditions that would impair or limit their ability to participate in outdoor wilderness activities that include hiking, back packing, rock climbing, exposure to natural elements?

Does the Participant take any prescription Medication? If so, please list dosage, name and reason for medication

PHYSICIAN'S INFORMATION (Please Print)	
Name	
Address	
Telephone	
Date	

 Physician's Signature M.D