Medical Release Form

Name:	Emergency Contact:
Address:	Emergency Contact Home Phone:
Home Phone:	Emergency Contact Cell Phone:
Cell Phone:	Physician:
DOB:	Physician Phone:

Insurance Information

Do you have insurance?	Policy Number:
Name of insured:	Insurance Phone:
Insurance Company:	Insurance Address

Medications

Medication	How much/often	For	Current Side Effects

Medical Allergies

Allergy	Reaction

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 2012 Grand Canyon 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

CORNERSTONE
RECOVERY

Medical History

Do you have, or have you had, any of the following conditions? Please check all boxes that apply.

☐01.Heart disease of any kind
☐02.Heart attack
☐03. Heart Murmur
☐04. Irregular heart beat
☐05. Heart palpitations
☐06. Chest pain or pressure
☐07. Circulation problems
☐08. High blood pressure
☐09. Unexplained sweating
☐10. Shortness of breath
☐11. Asthma
☐12. Chronic cough
☐13. Tuberculosis (TB)
☐14. Frequent Lung Infections
☐15. Ulcer
☐16. Heartburn
☐17. Intestinal problems
☐18. Active hepatitis
☐19. History of Hepatitis
☐20. Arthritis
☐21. Joint problems
☐22. Broken bones
☐23. Neck or back problems
☐24. Diabetes
☐25. Hypoglycemia
☐26. Thyroid problems
☐27. Unexplained weight loss
☐28. Obesity
☐29. Endocrine/gland problems
☐30. Vision Impairment
☐31. Cancer
☐32. Headaches
☐33. Seizure disorder
☐34. Seizure within last year
☐35. Significant head injury
☐36. Frequent dizziness
☐37. Frequent fainting
☐38. Learning disorder
☐39. Eating disorder
☐40. Psychiatric/Emotional problems
☐41. Difficulty urinating
☐42. Kidney problems
☐43. Bleeding disorders
☐44. Blood disorder/Anemia
☐45. Sickle cell trait or disease
☐46. HIV/AIDS
☐47. Medical equipment/devices
☐48. Skin problems
☐49. Special dietary needs
☐50. Special physical requirements
☐51. Bipolar Disorder
☐52. Mood Disorder
☐53. Post-Traumatic Stress Disorder
☐54. Major Depression
☐55. Other

IF YOU CHECKED ANY OF THE ABOVE ITEMS PLEASE EXPLAIN IN THE SPACE PROVIDED BELOW.

TO BE COMPLETED BY PHYSICIAN

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(required)	Polio	Hep B

Medical History

Last Tetanus 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?

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____
____
____
____

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

____**M.D**
Physician's Signature