



MEDICAL FORM

Please fill out all information below in order for HWWA staff and volunteers to provide you with the safest and most enjoyable environment possible for you on your trip. **Note: All information is confidential.** Return your Medical Form, Trip Registration Form, Release of Liability, and Payment to Healing Waters by dropping it off, mailing, e-mailing, or faxing.

PART ONE: PERSONAL INFORMATION AND HISTORY

1. Personal Information																	
Name: _____	Guardian (if under 18): _____																
Gender: _____ Date of Birth: _____	Email: _____																
Address: _____																	
City: _____	State: _____ Zip: _____																
Primary Phone: _____	Secondary Phone: _____																
2. Emergency Contacts																	
Name #1: _____	Relationship: _____																
Primary Phone: _____	Secondary Phone: _____																
Name #2: _____	Relationship: _____																
Primary Phone: _____	Secondary Phone: _____																
3. Health Insurance																	
Health Insurance Company: _____	Policy Number: _____																
City: _____ State: _____	Group Number: _____																
Phone: _____	Does Your Insurance Require Pre-Authorization? <input type="checkbox"/> Yes <input type="checkbox"/> No																
4. What Is Your Physical Activity Routine?	5. Swimming Ability (check one)																
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Activity</th> <th style="text-align: left;">Frequency</th> <th style="text-align: left;">Time/Distance</th> <th style="text-align: left;">Intensity</th> </tr> </thead> <tbody> <tr> <td colspan="4" style="border-top: 1px solid black; height: 20px;"> </td> </tr> <tr> <td colspan="4" style="border-top: 1px solid black; height: 20px;"> </td> </tr> </tbody> </table>	Activity	Frequency	Time/Distance	Intensity									<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;"><input type="checkbox"/> None</td> <td style="width: 25%; padding: 5px;"><input type="checkbox"/> Less Than 100 Yards</td> <td style="width: 25%; padding: 5px;"><input type="checkbox"/> Moderate</td> <td style="width: 25%; padding: 5px;"><input type="checkbox"/> Strong</td> </tr> </table>	<input type="checkbox"/> None	<input type="checkbox"/> Less Than 100 Yards	<input type="checkbox"/> Moderate	<input type="checkbox"/> Strong
Activity	Frequency	Time/Distance	Intensity														
<input type="checkbox"/> None	<input type="checkbox"/> Less Than 100 Yards	<input type="checkbox"/> Moderate	<input type="checkbox"/> Strong														
Note: Your activity level does NOT affect your eligibility to participate in this program	Note: Your swimming ability does NOT affect your eligibility to participate in this program																

PART TWO: MEDICAL INFORMATION

Important – Please Answer Each Question. If Your Answer is “None” You Must Initial In The Space Provided

1. Past History - Check All Past Conditions			
<input type="checkbox"/> Seizure	<input type="checkbox"/> Knee/Ankle/Back Problems	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Dizziness/Fainting
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Enlarged Liver	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Enlarged Spleen	
			NONE _____

2. Allergies – Include Medications, Contraindicated Medications, Foods, Bites/Stings, Animals, etc.

Allergy	Reaction	Frequency/Last Episode	Required Medication

NONE _____

3. Medications – Please list any medications including prescriptions, psychotropic and non-prescriptions drugs

Medication	Condition	Dosage	Side Effects

NONE _____

4. Recent Injuries

List any recent (within one year) or active illness, injuries, or medical conditions that could affect your participation on this trip:

NONE _____

5. Recent Emergencies

List any recent (within one year) ER/urgent care visits, hospitalizations, or surgeries that could affect your participation on this trip:

NONE _____

6. Special Equipment

List any certain necessary equipment that you currently use?

NONE _____

I hereby authorize and instruct Healing Waters Wilderness Adventures to administer first aid and/or emergency medical treatment and/or secure such medical services that may become necessary for, or for any minor on whose behalf I am signing.

I further understand that while Healing Waters Wilderness Adventures will undertake to provide reasonable first aid and/or medical treatment under the circumstances, certain situations may require the assistance of third party medical service providers. Should such third party medical services become necessary, I further understand and agree that any and all costs associated therewith are my sole responsibility, and I expressly release Healing Waters Wilderness Adventures from any and all financial obligations arising from such third party medical services. By signing this release I agree that I have read it carefully, agree with its terms, and I sign it of my own free will.

Signature: _____ **Date:** _____

Print Name: _____

Signature of Parent/Guardian: _____

(Required If Under the Age of 18)

For Office Use Only:	Reviewed By	Review Date	Hold – Doc Review	Hold – Questions	Cleared	Trip Date	Notes