Outdoor ESCAPES New Hampshire, LLC
49 Butternut Lane, Conway, NH 03818
Cell (603) 528-0136
www.OutdoorEscapesNewHampshire.com

MEDICAL FORM

To be completed for each participant

HEALTH INFORMATION

Date & Name of Adventure: _____

The information provided on this form will be kept confidential, and in the case you become ill or injured, will be reviewed by a physician who may contact you for additional information. The information doesn't necessarily influence your acceptance into this program. Your guide will use some of the information to help customize your experience.

Name: _____ Age: _____ Weight: _____ Height: _____ Sex: ____
Address: _____ City: _____
State/Province: _____ Zip/Postal Code _____
Daytime Phone _____ Nighttime Phone _____

Do you have any sensory or physical limitations? _____ If so, list and state how they affect you:

_____

Do you have any learning or emotional limitations? (This includes fear of heights, dogs, water, etc.) _____ They are:

_____

What are the medications, physical aids, or strategies that your condition requires?

_____

Are you currently taking any over-the-counter or prescription medications? _____
If yes, please list them and describe what they are for:

_____

Are you currently under the care of a medical specialist? _____ If yes, for what conditions?

_____

Do you have any food allergies or dietary restrictions? _____ If yes, please describe:

_____

Do you have any environmental or medicinal allergies? _____ If yes, please describe:

_____

Are you bringing an Epi Pen with you on the tour? _____ If so, who will be carrying it and where will it be stored?

_____

Please list any pertinent experience you have had. _____

Please describe what physical exercise you regularly take part in. How often? _____

Have you had a tetanus shot in the last 4 years? Yes No Have you been immunized against Hepatitis B? Yes No
Have you received all childhood disease immunizations? Yes No When was your last TB test? _____

Do you have any of the following?

_____Hemophilia	_____Lung disease, Asthma	_____Allergy to bee stings	_____Knee condition
_____Diabetes	_____Ulcer or other GI disorder	_____Any other allergies	_____Back condition
_____Hernia/ruptures	_____Heart defect/disease	_____Seizures or other CNS disorder	_____Arthritis

If you answered yes to any of the above, please describe the exact diagnosis and treatment:

_____

EMERGENCY INFORMATION

Participant's Name: _____
Participant's health insurance company: _____ Phone # _____
Policy # _____ Group # _____
Name of Policyholder _____
Relationship of Policyholder to Participant _____
Physician: _____ Phone # _____
Relative or close friend to be notified in case of emergency:
Name: _____Phone: (day) _____
City _____State _____ Zip _____ Phone: (evening) _____