Project Forty
Medical Information Form

General Information (Please print clearly)

Name: Date (today):
Address: Home Phone:
Business Phone:

Are you? M F Date of Birth: Height: Weight:

Contact Information

Family Physician: Business Phone:
Address:

If you do not have a family physician or your physician is unavailable, may Project Forty appoint a physician to treat you? **Y N**

Emergency Notification: Relationship:

Address: Home Phone:
Business Phone:

Insurance

Participants are responsible for medical expenses. Sickness and accident insurance is required.
Medical Insurance Provider: _____ Policy Number: _____
Policy Holder Name: _____ Provider Phone No.: _____

Swimming Ability

If you are participating in a water-based program, please rate your swimming ability (circle one)

no ability some ability average swimming ability good swimmer excellent swimmer

Medical History		
1. Date of last Tetanus Booster:	2. List medications you are currently taking and for what reasons:	
3. Please list allergies, your reactions to them, and required medication below.		
Allergies	Reaction	Medication
4. Please list conditions for which you have been hospitalized within the past year of for which you are currently undergoing treatment.		
Condition	Name & Location of Hospital	Treatment & Date

Print Name _____

5. If you now have, or have had any of the following symptoms or conditions, please **circle "yes"** and underline the specific condition. **If not, circle "no"**. See the Lead Facilitator if necessary.

a.	**yes**	**no**	dizziness, recurrent headaches, or change in level of consciousness
b.	**yes**	**no**	eye, ear, nose, throat, tonsils, or sinus symptoms
c.	**yes**	**no**	impairment of sight, hearing, or speech
d.	**yes**	**no**	chronic cough, bronchitis or asthma, coughing up of blood, or contact with tuberculosis
e.	**yes**	**no**	chest pain, shortness of breath, palpitation, ankle swelling, heart murmur, heart disease, high or low blood pressure
f.	**yes**	**no**	reaction to bee stings
g.	**yes**	**no**	sensitivities/allergies to: horse serum (tetanus antitoxin), sulfa, penicillin, or any other drugs
h.	**yes**	**no**	symptoms relating to the gastro intestinal tract (i.e. diarrhea, recurring abdominal pain, passing of blood, or ulcer of stomach or duodenum)
i.	**yes**	**no**	severe menstrual cramps or menstrual problems
j.	**yes**	**no**	albumin, sugar or blood in urine, kidney stone, frequency in urinating, bed wetting, or other urinary difficulties
k.	**yes**	**no**	muscle joint, knee or back pain, bursitis, arthritis, or sciatica
l.	**yes**	**no**	muscle or limb weakness, numbness, or tingling
m.	**yes**	**no**	benign or malignant growth or tumor
n.	**yes**	**no**	history of diabetes, thyroid imbalance, or hypoglycemia
o.	**yes**	**no**	dietary restrictions (i.e.: diabetic, low cholesterol, vegetarian, etc.)
p.	**yes**	**no**	episodes of depression., anxiety, hysteria, or nervousness
q.	**yes**	**no**	currently pregnant

Please include detail about any medical information that you circled **yes** for or may be relevant to your participation in this activity. See the Lead Facilitator if necessary**.**

Authorization for Emergency Medical Care

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1. I am aware of my past and present health and fitness for doing strenuous activity. I will participate in all program activities, except for those noted on this form by myself and/or my physician. Information about any and all prescription drugs that I am currently taking is noted on this form. I have completed this form to the best of my ability with full knowledge that any information withheld may increase the potential for serious injury or re-injury.
2. Should an accident or emergency occur that renders me unable to communicate, I hereby give permission to the physician selected by Project Forty to hospitalize and/or secure proper treatment for me, except as noted on this form.
3. Project Forty reserves the right to limit participation in its programs based on information submitted on this form.

Participant Signature: _____ Date: _____

If you are **under the age of 18**, you are required to obtain the signature of a parent or guardian.

Parent/Guardian Signature: _____ Date: _____

Lead Facilitator Signature: _____ Date: _____

Participant Review (Date & Initial) _____ _____ _____

Facilitator Review (Date & Initial) _____ _____ _____