HEALTH INFORMATION FORM

Participants Name:____

Date of Birth: _____________________ Age:_________

Parent's name(if minor):______________________________________

Health Insurance Company:__________________________________

Policy Number:____

Emergency contacts:

Name:____
Phone Number:____
Relationship:____

Name:____
Phone Number:____

Relationship:_______________________________________

Primary Physician: ___________________________________

Phone Number: _____________________________________

Health Information

Known Allergies (medication, pollens, food, other):

Please list any current health problems (including any conditions for which you are taking medication):

Please list any prescription medication you will be taking during the trip and what it is prescribed for: