

Medical Information

Fill this form out completely to allow for your participation on the course

Name: _____

Address: _____

Phone: _____

Name, Address, and Phone Number of a person to contact in case of an emergency:

Allergies: Do you have and allergic reactions? (ex: bees, drugs, foods, etc.) If so what are they?

Medications: Are you taking any medication? (ex: Tylenol, Orthonovo 777, Proventil, etc.) If so what are they and what are they for?

Physical Condition: Do you have any physical conditions that might limit or prevent you from participating in certain physical activities? If so, please describe such limitations and conditions on activities.

Injuries: Have you experienced any injuries (ex: dislocations, sprains, etc.) within the last three years? If so, list and identify when the injuries occurred and the extent of the severity of the injury. Have you fully recovered from this injury?

Physician: Have you ever been treated by a physician in the past year? Have you been hospitalized within the past year? If so, explain.

Primary Physician: Address and Phone Number

Insurance: By what insurance company are you covered? If possible, please include you I.D. number.

Please fold this form in thirds and tape in closed to maintain your confidentiality.

This form is the property of Ferris State University Adventure Education Program and will remain as a confidential record.
Only the instructors and Medical personnel have access to this information.

