Sonshine Wilderness Retreat

MEDICAL FORM

Group Name: _____ Group Coordinator Name: _____

Personal Information

Participant's name: _____Child's name_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____-_____-_____ Participant E-mail (very important):_____

D.O.B.: _____ Age: _____ Gender: Male ____Female ____ Height: _____ Weight: _____

Child D.O.B.: _____ Age: _____ Gender: Male ____Female ____ Height: _____ Weight: _____

Health Insurance Company: _____ Policy Number: _____

Participant's Physician: _____Physician's Phone _____-_____-_____

Child's Physician: _____Physician's Phone _____-_____-_____

Medical History

Check response that accurately describes your health history. *(Insert "P" for participant and/or "C" for Child)*

Yes	No		Yes	No	
___	___	Allergies: food, medicines, insects, plants	___	___	Hemophilia/bleeding disorder
___	___	Asthma/Respiratory problems	___	___	Hernia
___	___	Do you have an inhaler?	___	___	High blood pressure
___	___	Cancer/Leukemia	___	___	Low blood pressure
___	___	Convulsions/seizures/fainting spells	___	___	Kidney trouble
___	___	Epilepsy	___	___	Menstrual problems
___	___	Diabetes	___	___	Serious illness in the past 12 months
___	___	Headaches	___	___	Surgery in the past 12 months
___	___	Heart trouble	___	___	Emotional or mental problems

Explain any "Yes" answers: _____

_____

Current Medications

SWR Ministry leaders will not administer any medications, including aspirin, Tums, Tylenol, etc. If you need any over the counter medications, you must provide them. Be sure to tell Ministry leaders what medications you and/or your child are taking. List any medications that you will have with you:

_____

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Physician's Evaluation

The applicant will be taking part in strenuous outdoor activities that may include: hiking or backpacking at 8-12,000 feet in elevation, and/or an all day summit climb up to 14,433 feet in elevation. This will include high altitude, extreme weather, cold water, exposure, fatigue, and remote conditions where medical care cannot be assured. **The applicant is approved for participation**.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone Number: _____-_____-_____

Office Address: _____ City: _____ State: _____ Zip: _____

♦ **Doctor's signature is required to participate. No other form can be substituted. By signing below a physician is verifying the medical history given above and approving this individual to participate.**

Participant Signature

All sections of this form must be initialed or signed

Individuals who have not completed this form will not be allowed to participate. I have carefully read all the sections of this agreement, understand its contents, and have initialed all sections of this document. I have examined all the information given by myself, and/or my child. By the signature below, I certify that it is true and correct. Should this form and/or any wording be altered, it will not be accepted and the participant will not be allowed to participate.

X _____ _____

Participant's signature Date