Medical Information

General Information (please print)

Name _____

Address _____

City _____ State _____ Zip _____

Phone (____)_____ Email _____

Age_____ D.O.B. _____ Height _____ Weight _____

Gender: ____Male / ____ Female Dl or Passport #_____

Emergency Contact #1

Name _____ Relationship_____

Address _____

City _____ State _____ Zip _____

Daytime Phone (____)_____ Nighttime Phone (____)_____

Email _____

Emergency Contact #2

Name _____ Relationship_____

Address _____

City _____ State _____ Zip _____

Daytime Phone (____)_____ Nighttime Phone (____)_____

Email _____

Medical Information

Personal Physician

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

Medical Information

Blood Type _____

Medications currently prescribed and dosage being taken

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Drug/Food Allergies

_____ _____
_____ _____
_____ _____

Current Medical / Psychological Conditions

_____ _____
_____ _____
_____ _____

Medical Information

Have you been hospitalized within the past two years? If so, for what condition?

_____

_____

_____

Do you have any medical issues that would limit travel?

☐ None	☐ Dizziness / fainting spells	☐ Back / Neck Problems
☐ Heart Problems	☐ Epilepsy	☐ Digestive Problems
☐ Cancer	☐ Joint Problems	☐ Other _____
☐ Asthma	☐ Respiratory Problems	☐ Other _____
☐ Diabetes	☐ Blood Pressure Problems	☐ Other _____
☐ Drug Reactions	☐ Psychological Condition	☐ Other _____

Please explain any items identified.

_____

_____

Should you become ill and need hospitalization during the trip, please list any pertinent information necessary to the medical staff that would expedite your diagnosis and care. *(Example: fear of needles, family history of medical condition, etc.)*

_____

_____

_____

_____

Medical Insurance (Attach a photocopy of the insurance card)

Company Name_____ Group # _____

Policy Number _____Phone # _____

Address _____

Medical Information

Beneficiary Information

Name _____ Relationship_____

Address _____

City _____ State _____ Zip _____

Daytime Phone (____)_____ Cell Phone (____)_____

Email _____

This information is collected for emergency purposes only. Should you need medical care while on the trip, this form will be given only to qualified medical personnel.

I attest that the information included on this medical form is true to the best of my abilities, and I agree I will notify WCU immediately of any relevant changes in my health that occur prior to the start of travel. I grant permission, should I become ill, for this information to be presented to medical personnel so that my care may be expedited. I agree to the release of any records necessary for treatment, referral, billing, or insurance purposes.

Signature of Participant _____

Date Signed _____

Signature of Legal Guardian (If participant is under 18) _____

Date Signed _____