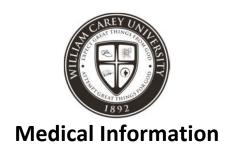
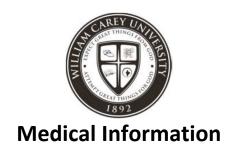


General Information (please print) Address City _____ State ____ Zip ____ Phone (____) ____ Email _____ Age D.O.B. Height Weight Gender: ____Male / ____ Female DI or Passport #_____ **Emergency Contact #1** Name Relationship Address _____ City _____ State _____ Zip _____ Daytime Phone (_____)_____ Nighttime Phone (_____)____ Email _____ **Emergency Contact #2** Name Relationship City _____ State ____ Zip ____ Daytime Phone (____)_____Nighttime Phone (____)



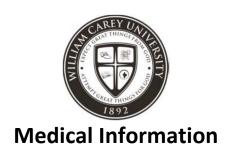
Personal Physician						
Name	Phone					
Address						
City	State	Zip				
Medical Information						
Blood Type						
Medications currently prescribed and dosage being taken						
	· · · · · · · · · · · · · · · · · · ·					
Drug/Food Allergies						
Current Medical / Psychological Conditions						



Have you been hospitalized within the past two years? If so, for what condition?					
		sues that would limit			
□ None□ Heart Problems		Dizziness / fainting spells		Back / Neck Problems Digestive Problems	
☐ Cancer		Epilepsy Joint Problems		Other	
☐ Asthma		Respiratory Problems		Other	
□ Diabetes		Blood Pressure Problems	Ш	Other	
☐ Drug Reactions		Psychological Condition		Other	
Please explain any items io	dentified				
Trouse emplain any nome is					
pertinent information	on neces	ssary to the medical s	staf	ng the trip, please list any f that would expedite your ary of medical condition, etc.)	
pertinent information	on neces	ssary to the medical s	staf	f that would expedite your	
pertinent information	on neces	ssary to the medical s	staf	f that would expedite your	
pertinent information diagnosis and care.	On neces	ssary to the medical s	staf histo	f that would expedite your ary of medical condition, etc.)	
pertinent information diagnosis and care. Medical Insurance (A	Example (Example	ssary to the medical see: fear of needles, family is	staff	f that would expedite your ary of medical condition, etc.) ance card)	
Medical Insurance (A	(Example	ssary to the medical se: fear of needles, family in a photocopy of the in	stafi	f that would expedite your ory of medical condition, etc.) ance card) Group #	
Medical Insurance (A	Example (Example	ssary to the medical see: fear of needles, family in a photocopy of the in	stafi histo	f that would expedite your ary of medical condition, etc.) ance card)	

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002 Medical Information Form:



Beneficiary Information	
Name	Relationship
Address	
	_ State Zip
Daytime Phone ()	Cell Phone ()
Email	
this form will be given only to qualified I attest that the information included a notify WCU immediately of any relevant permission, should I become ill, for this	gency purposes only. Should you need medical care while on the trip, d medical personnel. In this medical form is true to the best of my abilities, and I agree I will not changes in my health that occur prior to the start of travel. I grant information to be presented to medical personnel so that my care may be a y records necessary for treatment, referral, billing, or insurance purposes.
Signature of Participant	
Date Signed	
Signature of Legal Guardian (If particip	ant is under 18)
Data Signad	