REGISTRATION #_____

BECOMING AN OUTDOORS-WOMAN
Medical History Questionnaire

All Information is Confidential

Name_____ Date of Birth_____

Physician_____ Phone#_____

*Emergency Transport Contact Name_____ Phone#_____

*Emergency Transport Contact Name_____ Phone#_____

In case of emergency please notify_____ Phone#_____

QUESTIONS:

Please check any of the following medical conditions that apply to you:

□Yes □ No Are you allergic to any medication (aspirin, penicillin, etc.)? List_____

□Yes □ No Do you have any food allergies (nuts, seafood, fruits, etc.)? List_____

□Yes □ No Do you take any medication critical to your health? List_____

□Yes □ No Have you ever been told by a doctor that you have epilepsy? When_____

□Yes □ No Have you had recent surgical operations, accidents or injuries? When/What?_____

□Yes □ No Have you been "knocked out" unconscious, had a concussion or head injury? When?_____

□Yes □ No Are you pregnant?_____

Do you wear: □ glasses? or □ contact lenses?

Date of last tetanus immunization:_____

Please check any of the following medical conditions you have had within the last five years:

□ Environmental allergies. (Especially to bees, ants, pollen etc.) If yes, please list _____

If yes, bring your own Epi-Pen or inhaler. We don't provide them.

□ Heart Disease
□ Asthma – **please bring your own inhaler**
□ Diabetes
□ Seizures
□ Fainting spells
□ High blood pressure

Do you have any medical training?

□ Doctor □ Nurse □ Emergency Medical Technician □ Other_____

Is there anything else about your health you would like us to know in case of an emergency? _____

_____

Signature_____ Date_____

PLEASE RETURN THIS QUESTIONNAIRE WITH YOUR REGISTRATION FORM.

*Emergency transport contacts are someone that, if called on the day of the workshop, would be able to transport you to the hospital for a non-life-threatening injury or medical condition.

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