ADULT MEMBER'S HEALTH FORM

Name _____

Birth date _____

1. Do you have any physical complaints or chronic illness at this time?

   _____

   If so, what?_____

2. Are you under the care of a physician or practitioner of any sort?

   _____

   If so, why?_____

3. Are you taking medicines of any type? No ____Yes ____
   If Yes, Please list:

Medications*:

Name	Dosage
_____	
_____	
_____	
_____	

Are you on a special diet? _____

If so, what kind?_____

4. Do you have/ever had:
   a. Diabetes? _____ If yes, are you taking insulin? _____
      How much? _____ What kind? _____
   b. Asthma?_____
   c. Allergy? _____
   d. Any other disorder? _____

5. Physician's Name: _____

   Phone: _____

6. Insurance Company Name: _____

   Policy Number: _____

If I cannot be reached, in the event of an emergency, please contact:

Name _____ Phone _____

Name _____ Phone _____

In case of emergency, I hereby give permission to the physician selected by the event coordinator to hospitalize and secure proper treatment (including surgery).

I have read, understand and agree to the above listed statement and do sign this agreement of my own free will.

_____

SIGNATURE DATE

_____

ADDRESS CITY AND COUNTY ZIP

Home Phone _____ Cell Phone _____

Work Phone _____

This form must be reviewed, dated and initialed within 30 days of each trip you plan to attend:

Oct _____ Nov _____ Dec _____ Jan _____ Feb_____ Mar _____

Apr _____ May _____ Jun _____ Jul _____ Aug _____ Sep _____