Refuge Guide Service, LLC
Medical History Form

All information on this form is kept confidential. Only a medical reviewer and appropriate Refuge Guide Service, LLC staff/ leadership will have access to it. For your safety, please ensure all information on this form is accurate and complete. Medical conditions do not automatically disqualify you from participating in the activities of Refuge Guide Service, LLC and we will try to accommodate any medical restrictions or conditions you may have. However, refuge Guide Service, LLC does reserve the right to refuse participation to anyone it feels is medically unfit for the programs activities.

Refuge Guide Service, LLC is held outside in various types of terrain and conditions. **Failure to disclose medical information could result in serious harm to you and your fellow participants.**

Personal information: (Print)

Name:_____ Date of Birth: / / Age: _____

____ ____ ____

General information to be competed by the participant: *(All **YES** answers require explanation below)*

Do you regularly take any medications? YES NO

Do you have any allergies? YES NO

Do you have any physical or mental limitations we should be aware of? YES NO

Please explain any yes answers from above. Include specific symptoms, frequency of occurrence, duration of symptoms, date of last occurrence, and care for your symptoms, and any restrictions associated with your condition. Also include names of any medications to which you have had adverse reactions, any medications you are currently taking and any information you want provided to emergency personnel in case of a medical emergency. (Attach separate sheet if necessary)

_____

_____

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_____

EMERGENCY CONTACT:

NAME: _____ Relation: _____ Primary Phone: _____

Secondary Phone: _____ Text or email: _____

Insurance Information: <u>Please attach a valid copy of your Medical Insurance Card!</u> ***(Optional)***

Participant Acknowledgement *(must be signed by participant)*

The information I have provided above is complete and accurate to the best of my knowledge. I understand that only appropriate medical personnel or trail leadership will review this information. I authorize the medical reviewer to discuss this information with my medical provider or the leadership as needed to determine my fitness for this activity. **I understand that I may be in an area where communication, transportation or medical evacuation is subject to delay**. I give permission for any emergency anesthesia, operation, hospitalization or other treatment that may be necessary. I agree to be responsible for any and all costs associated with treatment or evacuation.

Signature:_____ **Date:**_____