

TRAILS CLUB BACKPACK MEDICAL INFORMATION

Please print your answers clearly. This form will be kept confidential.

Name of backpack: _____ Backpack dates: _____

Backpack leader: _____

Applicant Name: _____ DOB: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Email: _____

Emergency Contact

Name: _____ Relationship: _____

Phone number(s) _____

Doctor's Name: _____

Clinic Name & Address: _____

Phone: _____ Fax: _____ Email: _____

Medical Insurance

Name: _____ Group/Policy#: _____

Address: _____

Phone: _____ Fax: _____

The following information is necessary before participation in this Trails Club backpack. It is essential to have this information in case of illness or accident. Attach additional page if necessary.

1. Do you have any current medical problems, issues or limitations? No ____ Yes ____

If yes, please explain:

2. Have you had any previous medical conditions of which we should be aware? No ____ Yes ____

If yes, please explain:

3. List your current prescriptions, natural, and over-the-counter medication (aspirin & etc.) that you are now taking or have taken in the last few months: (drug name, dosage and frequency).

4. Allergies to food, medications, or the environment? No ____ Yes ____ Please list:

5. Current tetanus immunization? No ____ Yes ____ Please list date:

Your leader will keep a copy of this during the backpack in case it is needed. Please keep a copy of this completed form with you at all times during the backpack.

Signature of applicant _____ **Date** _____

Signature of parent or guardian if applicant is under 18 _____ **Date** _____