

Trip destination _____

Trip dates ____/____/____ to ____/____/____

Team ID number _____



Medical Questionnaire

Name: _____ Age: _____

Emergency Contact: _____ Phone: _____

Please answer the following questions. All information is confidential and will only be used in the event of a medical emergency.

1. Are you currently being treated for any medical condition? Yes No
a. If yes, please explain: _____

2. Are you currently taking any medications? Yes No
a. If yes, please list: _____

3. Have you ever had any psychiatric care or treatment? Yes No
a. If yes, please explain: _____

4. How would you describe your health and fitness?
 Excellent Good Average Below Average

5. Do you have any of the following conditions?

<input type="checkbox"/> Allergies	Explain: _____
<input type="checkbox"/> Allergies to Medications	Explain: _____
<input type="checkbox"/> Asthma	Explain: _____
<input type="checkbox"/> Blood Disorder	Explain: _____
<input type="checkbox"/> Heart Disease	Explain: _____
<input type="checkbox"/> Depression	Explain: _____
<input type="checkbox"/> Mental Illness	Explain: _____
<input type="checkbox"/> Migraine Headaches	Explain: _____
<input type="checkbox"/> Pulmonary Condition	Explain: _____
<input type="checkbox"/> Seizures	Explain: _____
<input type="checkbox"/> Fainting Spells	Explain: _____
<input type="checkbox"/> Eating Disorder	Explain: _____
<input type="checkbox"/> Other Condition Not Listed	Explain: _____

6. Are you under any doctor's restrictions regarding how much you can walk, lift or carry?
 Yes No Explain: _____

7. Do you wear glasses and/or contact lenses? Yes No

8. If you know, what is your blood type? _____

9. Check all the following that you have been immunized against:

Tetanus/Diphtheria within the past: 5 years 10 years

Typhoid Hepatitis A. Hepatitis B Other: _____

10. Other Health Notes: _____

