



CRAWDADDY OUTDOORS LC



CrawDaddy Outdoors LC does not offer or provide insurance for activities/trips. You are advised to acquire your own medical insurance.

If you do not have insurance, initial this line stating that you do not have health insurance and are aware that CrawDaddy Outdoors LC does not carry any health insurance for you.

\_\_\_\_\_ Initial \_\_\_\_\_ Date

## Annual Health and Medical Record

### GENERAL INFORMATION

Name \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  Male  Female

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone Number \_\_\_\_\_

Social Security No. (Optional) \_\_\_\_\_

**ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF YOU DO NOT HAVE MEDICAL INSURANCE, ENTER "NONE" ABOVE.**

### In case of emergency, notify

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Home phone \_\_\_\_\_ Business phone \_\_\_\_\_ Mobile Phone \_\_\_\_\_

Alternate contact name \_\_\_\_\_ Alternate phone \_\_\_\_\_

## HEALTH HISTORY

Do you currently have, or have you ever been treated for any of the following?

Yes	No	Condition	Explain
<input type="radio"/>	<input type="radio"/>	<b>Asthma</b> Last attack: (MM/YY)	
<input type="radio"/>	<input type="radio"/>	<b>Diabetes</b> Last HbA1c: (percentage)	
<input type="radio"/>	<input type="radio"/>	<b>Hypertension (High Blood Pressure)</b>	
<input type="radio"/>	<input type="radio"/>	<b>Heart disease/heart attack/chest pain/heart murmur</b>	
<input type="radio"/>	<input type="radio"/>	<b>Stroke/TIA</b>	
<input type="radio"/>	<input type="radio"/>	<b>Lung/respiratory disease</b>	
<input type="radio"/>	<input type="radio"/>	<b>Ear/sinus problems</b>	
<input type="radio"/>	<input type="radio"/>	<b>Psychiatric/ psychological and emotional difficulties</b>	
<input type="radio"/>	<input type="radio"/>	<b>Behavior/neurological disorders</b>	
<input type="radio"/>	<input type="radio"/>	<b>Fainting spells</b>	
<input type="radio"/>	<input type="radio"/>	<b>Seizures</b> Last seizure:	
<input type="radio"/>	<input type="radio"/>	<b>Sleep disorders (e.g. sleep apnea)</b>	Use CPAP: <input type="radio"/> Yes <input type="radio"/> No
<input type="radio"/>	<input type="radio"/>	<b>Abdominal/digestive problems</b>	
<input type="radio"/>	<input type="radio"/>	<b>Excessive fatigue or shortness of breath with exercise</b>	
<input type="radio"/>	<input type="radio"/>	<b>Knees, joint or back problems</b>	
<input type="radio"/>	<input type="radio"/>	<b>Allergies including medications</b>	
<input type="radio"/>	<input type="radio"/>	<b>Vision</b>	
<input type="radio"/>	<input type="radio"/>	<b>Other</b>	

**MEDICATIONS** List medications currently use. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

No Medications

Medication: _____	Medication: _____
Strength: _____	Strength: _____
Frequency: _____	Frequency: _____
Appropriate date started: _____	Appropriate date started: _____
Reason for medication: _____	Reason for medication: _____
Medication: _____	Medication: _____
Strength: _____	Strength: _____
Frequency: _____	Frequency: _____
Appropriate date started: _____	Appropriate date started: _____
Reason for medication: _____	Reason for medication: _____

I have read and understand this form's contents completely and have answered the above questions accurately.

I believe that I/participant am in good physical condition and that I/participant can participate fully in trip activities.

The staff of Crawdaddy Outdoors has my authorization to review and retain this form as protected health information for the purposes of the above program. The staff of Crawdaddy Outdoors has my permission to seek and or administer emergency care for the participant in the event that the participant or guardian cannot respond at the time of emergency and has authorization to provide this form to health care personnel for the purposes of the participant's emergency treatment in that event. I understand that Crawdaddy Outdoors is not responsible for any charges for such health care services provided to the participant.

I understand that I have the right to revoke, in writing, this authorization at any time; however, this authorization will automatically expire at the end of the above program. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and or disclose the participants protected health information have acted in reliance upon this authorization. Further, I understand that if a participant's health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

Date: \_\_\_\_\_ Signature of participant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of parent/guardian: \_\_\_\_\_