Medical Form

Please complete this form and return it to the Alliance for CT, Inc. office at least one month prior to the course start date.
We ask for this information so that our staff will know in advance of special medical conditions you may have, rather than learning about them in a crisis. Also, in the event of a serious injury or illness, this form provides emergency medical personnel with a useful medical history. After reviewing this form, Alliance staff may contact you to discuss whether the trip will be safe and enjoyable for you considering your medical history.

We will keep the information on this form confidential. It will be seen only by staff, medical personnel, or others who know and understand its confidential nature. The form will be retained along with your liability waiver for a period of time following the trip, after which it will be destroyed. If you choose not to go on the trip, this form will be destroyed immediately.

Please contact the Alliance for CT, Inc. office if you have any questions regarding the information on this form. Many pharmacies and drug stores have self-service blood pressure cuffs to help obtain accurate BP and pulse rates.

General Information

Name:_____ **Gender:** ○**Male** ○**Female**

Address: _____

City:_____ **State:**_____ **Zip Code:**_____

Home: (____)_____ **Work: (____)**_____ **Cell: (____)**_____

E-mail address:_____ **Date of Birth:**_____

Height:_____ **Weight:**_____ **Blood Pressure:**_____ **Resting Pulse:**_____

Emergency Contact:_____ **Relationship:**_____

Home: (____)_____ **Work: (____)**_____ **Cell: (____)**_____

If the above person is unavailable, please notify: _____ **Relationship:**_____

Home: (____)_____ **Work: (____)**_____ **Cell: (____)**_____

Medical Insurance Information

We strongly encourage you to have medical insurance and to bring you insurance card or other documentation on the trip.

Company Name: _____ Policy Number:_____

Contact Phone Number (if applicable):_____

Allergies

Include medicine, foods, animals, insect bites/stings, environment (dust, pollen, etc.). ☐ **NONE**

Allergy	Reaction	Medication (if any)

Medical History

Please list all prescription, over-the-counter, and natural medications you are taking.

Medication	Dosage	Frequency	Side Effects	Reason for Taking

- Any significant illness in the past two years? If yes, please explain here.

- Any accidents, operations, hospitalizations during the past two years? If yes, please explain here.

- Recent exposure to blood-borne infectious diseases? If yes, please explain here.

- Do you have asthma? ◯ **Yes** ◯ **No If yes, please list any medications above.**
- Do you have diabetes? ◯ **Yes** ◯ **No If yes, please list any medications above**.
- Do you have history of high blood pressure? ◯ **Yes** ◯ **No If yes, please explain .**
- Do you have issues with your eyes/vision? ◯ **Yes** ◯ **No If yes, please explain .**
- Do you have any issues with your hearing? ◯ **Yes** ◯ **No If yes, please explain .**
- Are you pregnant? ◯ **Yes** ◯ **No**
- Do you have bone, joint, or muscle issues? ◯ **Yes** ◯ **No If yes, please explain**
- Have you ever had a seizure? ◯ **Yes** ◯ **No If yes, please explain**
- Have you experienced altitude problems? ◯ **Yes** ◯ **No If yes, please expla** .
- Do you have any other medical issues that might affect your participation on this course? ◯ **Yes** ◯ **No**
  If yes to any of the above, please explain here:

  _____

  _____

- This course with Alliance for CT, Inc. may require vigorous activity, extended hiking and scrambling, and other physically and mentally demanding exertion in isolated areas without medical facilities, medical providers, or means of contacting rescue or medical personnel. Please state below all physical or mental limitations and restrictions of which you are aware:

  If you have no such limitations, please initial here____

  _____

  _____

- Anything else we should know? _____

  _____

Physical Examination

Date of most recent physical: ____/____/_____ Physician's name:_____

Address:_____ Phone number: _____

Please notify the Alliance for CT, Inc. office if any information on this form changes

Course Name: _____ Course Dates: _____

Signature (required): _____ Date: _____

Parent Signature (if under 18): _____ Date:_____

Parent Name:_____ Phone Number:_____