Seguin Outdoor Learning Center Health and Medical History Form

(This information will be treated with the strictest confidentiality)

GENERAL INFORMATION:

Name:_____Gender: M F Age:_____ Program Date:_____

Local address:_____City/State:_____

Local phone: ( )_____Zip:_____

Work or cell phone: _____ E-Mail Address:_____

EMERGENCY INFORMATION:

In case of emergency contact:_____Relationship:_____

Home Phone: ( )_____Work Phone: ( )_____Cell Phone: ( )_____

Address:_____City/State:_____Zip:_____

Your Health Insurance Company:_____Policy #:_____

Your Doctor's Name:_____Doctor's Phone: ( )_____

MEDICAL HISTORY:

Do you have any allergies?_____If so, what?_____

Are you currently taking medication(s)?____ If so, what and why?_____

_____

Recent or recurring injuries, recent surgeries, and/or disabilities:_____

_____

	Circle			Circle	
• Pregnant	yes	no	• Seizures	yes	no
• Diabetes	yes	no	• Asthma	yes	no
• High blood pressure	yes	no	• Heart attack	yes	no
• Chest pains	yes	no	• Heart disease	yes	no
• Shortness of breath	yes	no	• Family history of heart disease	yes	no
• Stroke	yes	no	• Episodes of anxiety or depression	yes	no

Current level of fitness: ☐ fewer than three 20-minute aerobic activities per week.
☐ three or more 20-minute aerobic activities per week.

Any activity limitations or other conditions you want us to know about: _____

_____

_____

_____

_____

I affirm the information above is accurate and true to the best of my knowledge and that I have not withheld any information that would result in a health risk while participating on the challenge course.

Signature_____ Date_____

(Participant or Parent/Guardian if under 18)