Health Information Form

Confidential Health Information Form

Participant's Full Name _____

Date of Birth _____ (mm/dd/yyyy) Height (in inches) _____ Weight (in lbs) _____

Health Insurance: All Program participants are required to carry health insurance that covers injury or illness while traveling outside of the United States, and includes MEDICAL EVACUATION.

** See Health Insurance and Consent-to-Treat Form for details.*

Do you have or have you had any disease or condition requiring medication, regular physician's care, surgery or other treatment? If yes, please list:

_____

_____

Do you take any medication(s) on a regular, on-going basis? If yes, please list:

_____

_____

Have you ever sought professional help for a psychiatric or emotional problem? If yes, please explain:

_____

_____

Do you have any of the following? If yes, please explain type and severity:

Medication Allergies	NO	YES	_____
Food Allergies	NO	YES	_____
Other Allergies	NO	YES	_____
Asthma	NO	YES	Require epinephrine or hospital? _____
Diabetes	NO	YES	Require insulin? _____
Epilepsy	NO	YES	Explain: _____

Do you have any other health condition that may need to be considered? If yes, explain:

_____

_____

_____

I understand that submission of inaccurate and/or incomplete information about medical and psychiatric health history may result in dismissal from the program. ☐ **Yes** ☐ **No (check one)**

_____ _____

Participant's signature Date (mm/dd/yyyy)