Edu-Ventures

Medical Information

DIRECTIONS

Please complete all sections of the form completely
Please print legibly and complete every section
Return this form to Edu-Ventures as soon as possible

GENERAL INFORMATION

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL_____

PARENT/LEGAL GUARDIAN LAST NAME_____ FIRST NAME:_____ MIDDLE INITIAL_____

CITY_____ STATE_____ ZIP CODE_____

HOME PHONE_____ WORK PHONE_____

TOUR INFORMATION

DESTINATION: _____ GROUP LEADER:_____ SCHOOL NAME:_____

EMERGENCY INFORMATION (In case of emergency, please contact:)

LAST NAME:_____ FIRST NAME:_____ MIDDLE INITIAL_____

HOME PHONE_____ WORK PHONE_____ RELATIONSHIP_____

MEDICAL HISTORY

☐	Y	☐	N	SERIOUS HEAD INJURY	☐	Y	☐	N	DIABETES	☐	Y	☐	N	CONVULSIONS/EPILEPSY/SEIZURES
☐	Y	☐	N	ARTHRITIS OR RHEUMATISM	☐	Y	☐	N	STOMACH TROUBLE/GERD/ULCERS	☐	Y	☐	N	DRUG OR ALCOHOL ADDICTION
☐	Y	☐	N	ASTHMA/SHORTNESS OF BREATH	☐	Y	☐	N	FAINTING SPELLS OR DIZZINESS	☐	Y	☐	N	PSYCHIATRIC OR PSYCHOLOGICAL CARE
☐	Y	☐	N	CHRONIC OR FREQUENT COUGH	☐	Y	☐	N	HEART DISEASE/HEART MURMUR					
☐	Y	☐	N	HAVE YOU BEEN EXPOSED TO ANY COMMUNICABLE DISEASES WITHIN THE PAST 6 MONTHS?										
☐	Y	☐	N	DO YOU HAVE ANY PHYSICA DISABILITIES/CONDITIONS WHICH MIGHT BE AGGRAVATED BY CHANGE OF DIET, CHANGE OF CLIMATE, CARRYING YOUR OWN LUGGAGE, OR EXTENDED/REGIONAL TRAVEL?										

☐ Y ☐ N DO YOU HAVE ANYSPECIAL HEALTH PROBLEMS OR ANY OTHER HEALTH INFORMATION NOT COVERED ABOVE WHICH WOULD BE USEFUL FOR THE GROUP LEADER OR ADVISOR TO KNOW? IF YES, PLEASE DESCRIBE _____

LIST CURRENT MEDICATIONS & DIETARY SUPPLEMENTS: _____
(Including over-the-counter medications & vitamins, as well as prescription drugs)

DRUGS/MEDICATIONS YOU ARE ALLERGIC TO: _____
(Including over-the-counter medications, as well as prescription drugs)

FOOD ALLERGIES:_____ OTHER ALLERGIES:_____
(hay fever, latex allergy, etc…)

ILLNESSES/INJURIES IN LAST 12 MONTHS THAT REQUIRED PHYSICIAN'S CARE:_____

SIGNATURES

1 understand that failure to disclose any medical/health problems, and/or history could result in increased health risk in case of emergency, or cancellation from the program. 1 understand that final program documents can only be sent out after this form is completed, signed, and submitted to Edu-Ventures. I am in good health and fit for travel.

_____ _____

Participant Signature **Date** **Parent/Legal Guardian Signature** **Date**

PLEASE RETURN THIS FORM TO EDU-VENTURES AS SOON AS POSSIBLE

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