**Medical Form**

**Personal information**

|  |  |  |
| --- | --- | --- |
| Name: | DOB: | Phone: |
| Address: |

|  |  |
| --- | --- |
| Emergency contact name: | Phone: |
| Address: |

**Medical and Physical Information**

Please list any/all medical conditions, and physical conditions that should be known in case of emergency (i.e. respiratory problems, cardiac problems, pregnancy, previous frostbite, heat related illness, eyesight/hearing, balance/vertigo, previous head injury), allergies:

**Mental Health Information**

Are you currently under counseling with a mental health professional for suicide, anxiety disorders, personality disorders, substance abuse, eating disorders, depression, other? Have you been hospitalized for mental illness?

**Medication Information**

Please list medications that you are on, reason for use, and frequency of use: