3566 Veterans Memorial Highway
Lithia Springs, GA 30122
Phone: 770.948.2126

Participant's Medical Profile and History

Name: ____
(Print)

Address: ____

Phone: ____
(Home) (Cell) (Work)

Health Insurance Company: ____
Address: ____
Phone: ____
Policy Number: ____

Primary Care Physician: ____
Address: ____
Phone: ____

Emergency Contact:
Name: ________________________________ **Relation:** _______________
Phone: ____
(Home) (Cell) (Work)

Generally, my health is: (Check one)
_____ **Excellent** _____ **Good** _____ **Fair** _____ **Poor**

If, Fair or Poor, please explain why: ______________________________________
____

Tetanus Shot: Date received: ______________________
****

Check any of the following conditions or diseases you currently have or have had:

_____ADD/ADHD
_____Anemia
_____Anxiety Attacks
_____Appendicitis
_____Asthma
_____Bronchitis
_____Chickenpox
_____Chronic Headaches
_____Dizziness/Fainting
_____Diabetes
_____Diagnosed phobias
_____Epilepsy
_____GI/Stomach Disorder
_____Hay Fever
_____Heart Disorder
_____Hyperglycemia
_____Hypoglycemia
_____Hypertension
_____Influenza
_____Kidney Disorder
_____Measles
_____Meningitis
_____Migraines
_____Mumps
_____Pneumonia
_____Pleurisy
_____Polio
_____Sinusitis
_____Tetanus
_____Thyroid Disorder
_____Tuberculosis

3566 Veterans Memorial Highway
Lithia Springs, GA 30122
Phone: 770.948.2126

Participant's Medical Profile and History

Are there any other conditions or diseases that you currently have or for which you are receiving treatment? These may include psychological as well as physical conditions. If so, please specify the condition and the treatment, if any, that you are receiving.

____
____
____
____

Please list any prescribed medication(s) you will be taking while on this trip.

Medication	*Dosage*	*Frequency*

Please list any allergies that you may have:

Allergy	*Medication/Treatment*

Please describe any other special needs or conditions that you may have. These may include significant hearing, sight, or speech impairments, various physical disabilities, restricted diets, etc. ____
____
____
____

3566 Veterans Memorial Highway
Lithia Springs, GA 30122
Phone: 770.948.2126

Participant's Medical Profile and History

Please list any major operations you have had and give the approximate date of the surgery.

ALL PARTICIPANTS MUST SIGN:

My signature below indicates that I have read this entire document, understand it completely, and have provided as accurately as possible my medical conditions and needs.

Signature of Participant: ____

Date Executed: ____

SIGNATURES MUST BE WITNESSED:

Signature of Witness: ____
(Print) (Signed)

Date executed: ____

(Signature of both parents, or parent with legal custody, or legal guardian is required if participant is under 18 years of age)

Signature of father: ____
_____ Sole Legal Custody Date: ______________________________

Signature of Mother: ____
_____ Sole Legal Custody Date: ______________________________

Signature: Legal Guardian: ____
_____ Sole Legal Custody Date: ______________________________

Signature of Witness: ____

Date executed: ____