WESTMONT

Pre-Course Health Record
Adventure Trips

REGISTRATION
Trip Name: _____

PARTICIPANT
Name _____ Daytime Telephone # (____)_____
Age _____ DOB ___/___/___ Gender _____ Evening Telephone # (____)_____
Address _____ Apt. _____ Email _____
City/State/ZIP _____

EMERGENCY CONTACT
Name_____
Relationship_____
Daytime Telephone # (____)_____
Evening Telephone # (____)_____

PHYSICIAN
Name_____
Telephone # (____)_____
FAX # (____)_____
email_____

INSURANCE INFORMATION
Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance. Please answer for the following questions for our insurance records:
Do you have insurance? Yes ☐ No ☐
Insurance Company_____ Policy/Certificate #_____
Prescription Plan #_____ Telephone # (____)_____

ALLERGIES (including allergies to medicines, foods, insect bites/stings,etc.

Allergy	Reaction	Medication Required

CURRENT MEDICATIONS (including psychiatric medication, over-the-counter medication, inhalers, etc.)

Medication	Taken For: (symptom/condition)	Dosage	Date Started	Current Side Effects

HEALTH PROFILE Please describe any physical/mental/medical conditions (including current pregnancy, etc.) or medical history that might affect your participation. _____

Do you have any dietary restrictions? (i.e. vegetarian, diabetic, allergies, etc). Yes ☐ No ☐
If yes, please describe _____

I have accurately answered all of the previous questions and I understand that failure to disclose such information could result in serious hard to my fellow participants and me. I also understand the risks of participating with any current medical conditions. It is my responsibility to ensure that I am able to physically participate in the program offering. If I have any questions, I will consult a physician.

_____ ____/____/____
Applicant's Signature/Parent or Legal Guardian Signature (if Participant is under 18) Date