Family Name:

Emergency Information and Medical Certification

Personal information:

Full Name: _____ Date of Birth: _____

Field Activity: _____ Trip start date: _____

The following information may be critical to caring for you in case of an injury or sudden illness during the Activity. It will be used **only in the event of an emergency**, and only if you are unable to communicate this information to those treating you. This form will be destroyed at the conclusion of the Field Activity.

Personal Health/Accident Insurance:

Company: _____ Policy/ID Number: _____

Known Dangerous Allergies (please list): (e.g. medicine, food, plant, animal, insect toxin):

Medical Certification:

Please provide any information you wish regarding medical condition currently requiring special care, medication, or diet that can adversely affect or limit personal health or safety in the activities described in the overview letter. These may include, but not be limited to: (limited mobility/hearing/sight, fear of heights, dangerous allergies, medical conditions other than those listed below, and pregnancy).*

☐ The following conditions require a licensed physician or nurse practitioner to certify your fitness to participate in the Activity:

- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Convulsions/seizures
- ☐ Diabetes
- ☐ Fainting Spells
- ☐ Heart Trouble
- ☐ High blood pressure

I hereby authorize release of the information herein to medical personnel in case of emergency:

Signature : ***Date:***

Name (printed): _____

Contact the following people in the event that I cannot communicate with them myself:

Name: _____ Relationship: _____

Telephone: Day: _____ Evening: _____ Mobile: _____

Alternate Personal Contact:

Name: _____ Relationship: _____

Telephone: Day: _____ Evening: _____ Mobile: _____