

Medical Form



Instructions for Completing this Form

Please complete and sign this form and return it to SFCT within 5 days of registering for the trip. Please review the trip description and Trip Participant Release Form in conjunction with completing this form. It is critical that you provide honest, accurate and complete information. SFCT requests this information to assist staff and the trip leader in understanding health issues, to consider potential modifications and for use during emergencies. This information may be shared with the trip leader and medical professionals or others, only as necessary, to address participant's health and medical issues. Otherwise this information will remain confidential.

General Information

Trip name: _____ Dates of Trip: _____

Full name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Mobile phone: _____

Home phone: _____

Emergency Contact: _____

Relationship: _____

Phone: _____

Travel and Medical Insurance

If you have medical insurance please bring your insurance card or other documentation with you on the trip.

Medical Insurance

Company name: _____

Policy number: _____

Contact phone number: _____

Allergies

Include allergies to food, insect bites and stings, medicines, animals, and the environment (dust, pollen, etc). Use a separate sheet if needed.

Select if no allergies

Allergy	Reaction	Medication required (e.g. epipen, antihistamine)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications

Please list all prescriptions, over the counter, natural medications, medical marijuana and inhalers you are currently taking. Include prescription medications taken for episodic or emergency use. Note if this is a recent change in dosage or prescription. Use a separate sheet if needed.

Medication name	Current side effects	Reason for taking (symptom/condition)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

General Medical History

Please complete the following medical history questions. If answering YES, use the box provided or a separate sheet to explain history in more detail and note if the medical condition has been a problem in the past 12 months. Do you currently have, or have you had a history of:

Asthma or other respiratory issues: Yes No _____

Diabetes (type 1 or 2): Yes No _____

Gastrointestinal issues: Yes No _____

Cardiac issues or hypertension: Yes No _____

Neurological issues: Yes No _____

Seizures: Yes No _____

Memory issues: Yes No _____

Vision / eye issues: Yes No _____

Hearing issues: Yes No _____

Bone, joint, muscle issues: Yes No _____

Any procedure, surgery, or replacement of a joint, muscle tendon, or bone: Yes No _____

Head trauma, traumatic brain injury: Yes No _____

Have you had any serious illness in the past 6 months? Yes No _____

Have you had surgery or been hospitalized in the last year? Yes No _____

Have you ever had problems related to exposure to altitude? Yes No _____

Are there other conditions or limitations (mental, emotional, or physical) that may affect your participation on this trip? If yes, please explain
 Yes No _____

Have you had a tetanus shot within the last 10 years? Yes No _____

Date of most recent physical: _____ Medical provider's name: _____

Address: _____ Phone: _____



Coronavirus Addendum

Reducing the risk of COVID-19 transmission to other participants, trip leaders and further, to the communities that we visit is a goal we all share. This screening will not identify people who may be infected but not yet showing symptoms or those who may be infected but simply do not show symptoms (“asymptomatic”). We ask that you complete the following questions to help lessen the spread of COVID-19.

Have you been fully vaccinated against COVID-19? Yes No

Dates of vaccination: DAY/MONTH/YEAR ____/____/____ DAY/MONTH/YEAR ____/____/____

Have you received a booster vaccination? Yes No Date ____/____/____

If within 2 weeks before your travel date you are diagnosed with COVID-19, develop COVID-19 like symptoms or are in close contact with someone who tested positive you will be required to cancel from the outing. The pandemic is a fluid situation. Knowledge, protocols and guidelines can change. Any changes to the requirements listed in this addendum will be communicated to you by SFCT.

Please sign and date below:

I certify that the information provided above is true, complete, and accurate. Other than any limitations described in this form, or any other information I have provided, I agree I can participate in all trip activities. I agree to contact SFCT promptly to provide additional information if my medical or health condition changes before the start of or during the trip. I acknowledge that falsifying or providing inaccurate or incomplete medical information can create serious risks to me or to others and may result in dismissal from the trip. I reaffirm the participant responsibilities agreed to in my Trip Participant Release Form. I understand my final acceptance in the trip is contingent upon SFCT and trip leader receipt and review of all required forms and information.

Print name: _____ **Date:** _____

Participant signature: _____