EASTERN OUTDOOR EXPERIENCES - Participant Health History

Name: _____Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Email: _____

Gender: □ Male □ Female

TODAY'S DATE: _____

Emergency Contact Information

Contact Name: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____

Health History

1. List all known allergies (Medicine, Environmental, Food allergies): _____
   _____
   Do you carry an Epi Pen or other medication? _____
2. Do you have asthma? _____
   When did you last use an inhaler? _____
3. Do you have diabetes? _____If yes, do you require insulin or other medication? _____
4. Do you have a history of seizures? _____
   If yes, do you currently take any medication? _____
5. Do you have heart disease or other heart conditions? ____
   If yes, please explain: _____
6. Have you ever had any musculoskeletal injuries/surgeries? _____ If yes, please explain: _____
   _____
7. Do you have any issues with your vision or hearing? _____If yes, please explain: _____
8. Have you ever had a heat related injury (heat stroke or heat exhaustion)? _____
   If yes, please explain: _____
9. Have you ever had a cold weather injury (hypothermia, frostbite/frostnip)? _____
   If yes, please explain: _____
10. Are you currently taking any medications for medical issues listed above? _____
    If yes, please explain: _____
11. Do you have medical insurance? _____
    If yes, who is your carrier? _____

COVID-19
Have you had close contact with or cared for someone diagnosed with COVID-19 within the last 14 days? _____
Have you experienced any cold or flu-like symptoms in the last 14 days? If yes, explain: