

# Participant Information Form

All participants must complete the Participant Information Form. PLEASE PRINT

Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
(Last, First, Middle Initial)

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Home Email \_\_\_\_\_

Company or School (if applicable) \_\_\_\_\_ Occupation \_\_\_\_\_

Work Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Email \_\_\_\_\_

Name of person to notify in case of emergency \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

# Medical Information Form

Complete the Medical Information form after you have read the General Health Information Guide on the back of this form. This information will be kept confidential. PLEASE PRINT

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Policy Number \_\_\_\_\_

Do you have now, or have you ever had any of the following? Check those which apply and explain below.

- Asthma/Respiratory Concerns     Heart Problems     Hypertension     Diabetes     Seizures  
 Orthopedic Concerns     Any active or chronic medical condition     Other

Please explain items checked above: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any drug allergies?     YES     NO    Reaction: \_\_\_\_\_

Are you allergic to insect bites/stings?     YES     NO    Reaction: \_\_\_\_\_

Are you currently taking medications?     YES     NO    Name of Medication/Purpose: \_\_\_\_\_

Have you had surgery in the last two years?     YES     NO    Type of Surgery/Restrictions: \_\_\_\_\_

Are you pregnant?     YES     NO    Any Complications: \_\_\_\_\_

Do you have any physical challenges we need to accommodate?  
 YES     NO    Please Explain: \_\_\_\_\_