

YOUNG MEN'S ULTIMATE WEEKEND

VOLUNTEER MEDICAL INFORMATION FORM

Name: _____

Address: _____

DOB: _____ Age: _____ Today's Date: _____

Home Phone: _____

Emergency Contact Person: _____

Emergency Contact Phone: _____

Doctor's Name: _____

Doctor's Phone: _____

Med Insurance Carrier Name: _____

Insurance Group/Plan #: _____

Check all items that apply, past or present, to your health history.

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Asthma	_____	_____	Diabetes	_____	_____
Cancer/leukemia	_____	_____	Heart Trouble	_____	_____
Convulsions	_____	_____	Hemophilia	_____	_____
Seizures	_____	_____	High blood pressure	_____	_____
Kidney Disease	_____	_____			

Explain "YES" answers or describe other conditions not listed above: _____

List any medication you will be taking during the weekend: _____

List all allergies (medicine, food, etc.) we should know about: _____

List any special dietary requirements we should know about: _____

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or strenuous physical games: _____

List equipment needed, such as wheelchair, braces, glasses, contact lenses, etc.

Immunizations: (Yes / No and provide date of last inoculation, if known)

Tetanus Toxoid _____	Measles _____	Polio _____
Diphtheria _____	Mumps _____	Chicken Pox _____
Pertussis _____	Rubella _____	

Please indicate if you have a history of disease or any health issues related to:

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Serious Illness _____	_____	_____	Chest/Lungs _____	_____	_____
Serious Injury _____	_____	_____	Heart _____	_____	_____
Deformity _____	_____	_____	Murmurs _____	_____	_____
Surgery _____	_____	_____	Rhumatic Fever _____	_____	_____
Skin/Glands _____	_____	_____	Stomach/Bowels _____	_____	_____
Ears/ Eyes _____	_____	_____	Appendicitis _____	_____	_____
Nose/Sinus _____	_____	_____	Kidneys/Urine _____	_____	_____
Teeth/Tonsils _____	_____	_____	Albumin _____	_____	_____
Dentures/Bridge _____	_____	_____	Sugar _____	_____	_____
Hernia _____	_____	_____	Back/Limbs/Joints _____	_____	_____

Explain "YES" answers or describe other conditions not listed above:

In the event that I am incapacitated due to a medical emergency, an injury, or an illness, I understand that reasonable effort will be made to contact my physician and the emergency contact person listed on this form. Further, I hereby authorize a representative of YM UW to act as agent with full power in my name to transport me to the closest appropriate medical facility for evaluation and treatment. Treatment could include anesthesia, surgery, or injection of medication.

Volunteer Name (print) _____

Volunteer Signature _____

Date _____