EVERGREEN
THE EVERGREEN STATE COLLEGE
OLYMPIA, WASHINGTON

Medical History

Name _____ Birth date _____ Phone Number _____

Address: _____
STREET CITY STATE ZIP

Insurance Carrier _____ Policy Number _____

Physician _____ Phone Number _____

Medical History of Participant: Please answer the following questions to the best of your knowledge. Use the back of form if needed (indicate that you've done so).

NO YES

☐ ☐ Do you have any physical complaints or chronic illnesses at this time?

If yes, please describe _____

☐ ☐ Have you had injuries in the past (back, knee, shoulder, elbow, etc.)?

If yes, please describe _____

☐ ☐ Are you currently under the care of a physician or practitioner of any kind?

If yes, please describe _____

☐ ☐ Are you taking medicines?

If yes, list condition, dosage, and how long _____

☐ ☐ Are you on a special diet? If yes, specify _____

Do you have, or have you ever had:

☐ ☐ Diabetes If yes, are you taking insulin ? _____ How much? _____

☐ ☐ Seizures If yes, when was your last seizure? _____

☐ ☐ Asthma If yes, when was your last attack? How severe? _____

☐ ☐ Allergies, Please specify _____

☐ ☐ Allergies to bee stings? Type of reaction _____

☐ ☐ Trouble breathing? If yes, describe. _____

☐ ☐ Heart Trouble? If yes, describe. _____

Please specify any other medical conditions and medications. _____

_____

_____

_____

I approve of emergency care for myself, or the above minor, under the direction of the event leader or consulting doctor, if I am unable to make my wishes known. (Cross out the above statement if you do not wish to grant medical consent.) I have filled out the above section to the best of my knowledge. If I am an adult, I read and understand the risks of exercise information and have consulted a physician if I have any cardiac risk.

Signature _____ Date _____