



WGO Emergency Medical Information

Team Number: _____

Name: _____
(Last) (First) (Middle Initial)

Gender: M F Age: _____ Birth Date: _____

Parent's Name (if under 21): _____

Parent's Phone: (____) _____ Work: (____) _____

HEALTH INFORMATION (To be completed by all participants):

Check the following boxes (If "Yes" please explain):

- Yes No Do you have any Drug Allergies? _____
- Yes No Do you have any Food Allergies? _____
- Yes No Do you have any Environmental Allergies? _____
- Yes No Has any allergic reaction required emergency room care? _____
- Yes No Do you have a Heart Condition? _____
- Yes No Do you have High Blood Pressure? _____
- Yes No Do you have any Respiratory Difficulties? _____
- Yes No Are you diabetic? Diet Controlled Oral medication Insulin
- Yes No Do you wear contact lenses?
- Yes No Have you had any serious illness or surgery within the past three years? If so, list with dates.

- Yes No Have you ever been treated for anxiety, nervousness, or stress related disorders? If "yes" please explain _____

Are you subject to: (If "yes" please explain)

- Yes No Fainting? _____
- Yes No Sleep Walking? _____
- Yes No Frequent Upset Stomach? _____
- Yes No Do you have any condition that would prevent you from participating in any activities? _____

Please indicate **ANYTHING** else that the leaders should know to help deal with any situation that might arise:

LIST ALL CURRENT MEDICATION, DOSAGE, AND WHAT IT IS BEING TAKEN FOR:

(Continue medications on the back if necessary)

PLEASE LIST ANY OTHER MEDICATIONS THAT YOU WILL BE TAKING TO HONDURAS:

EMERGENCY CONTACT INFORMATION: MUST BE INCLUDED

Emergency contact: _____ Relationship _____

Address: _____
(Street) (City) (State) (Zip)

Telephone: Home (____) _____ Work (____) _____

Primary Physician: _____ Phone (____) _____