Contact Information and Medical Form

Participant's General Information (Please Print Clearly)

Full Name:___________________________ Gender: M / F Age:_____ Birth Date: _______
Parent/Guardian information: Full Name: ____
Street Address:___________________________ Mailing Address (if different):
City:___________________________________
State:________________ Zip code:___________

Emergency Contact Information

Primary Contact in the case of an emergency: Name_____________________ Relation________
Street______________________ City _________________ State _________ Zip _________
Day Phone ______________ Night Phone ____________ Cell ____________ Pager ___________
Secondary Contact: Name _____________________ Relation________
Street______________________ City _________________ State _________ Zip _________
Day Phone ______________ Night Phone ____________ Cell ____________ Pager ___________

Medical Coverage & History

Does the participant have medical insurance? Yes / No If no, your signature on this form indicates that you will pay for any and all medical claims related to your participation in the program you have registered for with the University of Maine at Presque Isle.
Name of insurance provider: ____
Primary Care Giver: ____ Phone: __________________

Please check all "Yes" or "NO" boxes that apply to the participant. Does the participant have or has experienced any of the following conditions?

NO	YES	
☐	☐	Problems with hearing
☐	☐	Dizzy spells, fainting, convulsions
☐	☐	Shortness of breath, asthma
☐	☐	Chest pain on exertion
☐	☐	Palpation of the heart, irregular heartbeat, heart murmurs
☐	☐	Low or high blood pressure
☐	☐	Heart attack
☐	☐	Hernia
☐	☐	Chronic pain in the neck, back, shoulders, arms, or legs
☐	☐	Broken bones, dislocations, sprains, weakness of muscles
☐	☐	Joint pains, swelling, or stiffness without injury
☐	☐	Any severe injury to the head, chest, internal organs
☐	☐	Any surgeries
☐	☐	Severe illness requiring hospitalization or incapacitation
☐	☐	Episodes of depression, anxiety, hysteria, nervousness
☐	☐	History of diabetes, thyroid trouble, bleeding problems
☐	☐	Currently on any Medications? Please List:____
☐	☐	Special dietary restrictions / food allergies ____
☐	☐	Hypoglycemia

(Please Continue on Back)

List the details below if you answered “YES” to any of the previous questions. (Please include dates, medications, history, current condition, etc.)

____
____
____
____

Are there any other conditions that might effect the participant’s safe participation in this program?

____
____
____
____

Is the participant allergic to any of the following?

Medications (i.e. aspirin, sulfa drugs, ibuprofen, etc.) ___________________________________

Insect Bites (i.e. bee stings, etc) ____

Others (i.e. odors, plants, materials, etc.) ____

If so, what is the nature of the reaction?____

Does the participant carry medication for the reaction? Yes / No What? ______________________

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I request that this Release be construed and interpreted pursuant to the laws of the State of Maine, and if any portion thereof is held invalid, I request the remainder continue in full force and effect. I declare that I completely understand and have fully informed myself of the terms and conditions of this Release by having read it, or having it read to me, before signing.

______________________________	______________________
Name	Date
______________________________	______________________________
Signature	Signature of Parent of Guardian if under 18