

2010 Participant Medical History Form

Fiji

- Group A: March 14-28, 2010
- Group B: July 15-25, 2010
- Group C: July 29-August 8, 2010

Panama

- Group A: February 25-March 7, 2010
- Group B: March 11-21, 2010
- Group C: March 24-April 4, 2010

NAME _____

ILLNESSES

- | | | | |
|--|--|--|---------------------------------|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart disorder | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy (seizures) | <input type="checkbox"/> Migraine headaches | |

Other illnesses or explanation of the above: _____

INJURIES

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Recurrent ankle injury | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Sprained back | <input type="checkbox"/> Recurrent knee injury | <input type="checkbox"/> Other: _____ |

List broken bones, if any: _____

MEDICATIONS

Please list all current medications you take. Include the name, amount (dose) and how often you take it (frequency):

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

DIETARY

Please list any dietary requirements that must be observed: _____

INSURANCE

Name of parent's medical insurance company: _____

Policy Number: _____