Craftsbury
OUTDOOR CENTER

Program Participant Medical Information Sheet

THIS FORM IS REQUIRED

In order to better respond to your needs in a medical emergency, we are requesting the following information.
Please complete & return this form to the office.
All information is considered confidential & will be shredded after your departure.

PLEASE PRINT

Name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (H) _____ (W) _____ Gender: M / F

Dates attending: _____

Program attending (please circle): Sculling or Running

EMERGENCY CONTACT INFORMATION

Please list two people that we may notify in case of an emergency:

Name: _____ (Relationship) _____

Address: _____

Home Telephone: (___) _____ Alternative #: (___) _____

Name: _____ (Relationship) _____

Address: _____

Home Telephone: (___) _____ Alternative #: (___) _____

INSURANCE INFORMATION

Name of Policy Holder: _____

Name of Insurance Company: _____

Policy Number: _____

HEALTH INFORMATION

Please state any medical conditions such as allergies, injuries, diabetes, heart condition, seizures, or other conditions that would be important for us to know in case of an emergency.

_____

_____

_____

_____

Do you require prescription medications? (Please list type, reason for medication, and dosage).

_____

_____

_____