YOUNG MEN'S ULTIMATE WEEKEND

VOLUNTEER MEDICAL INFORMATION FORM

Name: ______________________________

Address: ______________________________

DOB: __________ **Age:** __________

Home Phone: ______________________________

Emergency Contact Person: ______________________________
Emergency Contact Phone: ______________________________
Doctor's Name: ______________________________
Doctor's Phone: ______________________________
Med Insurance Carrier Name: ______________________________
Insurance Group/Plan #: ______________________________

Check all items that apply, past or present, to your health history.

	YES	NO		YES	NO
Asthma			Diabetes		
Cancer/leukemia			Heart Trouble		
Convulsions			Hemophilia		
Seizures			High blood pressure		
Kidney Disease					

Explain "YES" answers or describe other conditions not listed above:

List any medication you will be taking during the weekend:

List all allergies (medicine, food, etc.) we should know about:

List any physical or behavioral conditions that may affect or limit full participation in swimming, backpacking, hiking long distances, or strenuous physical games:

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PAGE 2

List equipment needed, such as wheelchair, braces, glasses, contact lenses, etc. ____________________

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Immunizations: (Yes / No and provide date of last inoculation, if known)

Tetanus Toxoid	________	Measles	________	Polio	________
Diphtheria	________	Mumps	________	Chicken Pox	________
Pertussis	________	Rubella	________		

Please indicate if you have a history of disease or any health issues related to:

	YES	NO		YES	NO
Serious Illness	________	________	Chest/Lungs	________	________
Serious Injury	________	________	Heart	________	________
Deformity	________	________	Murmurs	________	________
Surgery	________	________	Rhumatic Fever	________	________
Skin/Glands	________	________	Stomach/Bowels	________	________
Ears/ Eyes	________	________	Appendicitis	________	________
Nose/Sinus	________	________	Kidneys/Urine	________	________
Teeth/Tonsils	________	________	Albumin	________	________
Dentures/Bridge	________	________	Sugar	________	________
Hernia	________	________	Back/Limbs/Joints	________	________

Explain "YES" answers or describe other conditions not listed above: ____________________

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In the event that I am incapacitated due to a medical emergency, an injury, or an illness, I understand that reasonable effort will be made to contact my physician and the emergency contact person listed on this form. Further, I hereby authorize a representative of YMAW to act as agent with full power in my name to transport me to the closest appropriate medical facility for evaluation and treatment. Treatment could include anesthesia, surgery, or injection of medication.

Volunteer Signature ______________________________

Date ____________________