Ties That Bind, Inc.
Medical Information

Name: (print) _____Phone:_____

Address: _____City: _____State____Zip:_____

Name of Personal Physician:_____ Phone _____

Emergency Contact: _____Phone_____

Do you have health/accident insurance? _____ If so, list carrier/policy # _____

Are you taking any medication, prescribed or otherwise? If **yes**, please list medication and condition._____

Do you have any physical or health disabilities that may be limiting? If **yes**, please explain.

_____

Please list known allergies to medications, insect bites, foods, etc._____

Do you have Asthma?_____

Do you currently have any of the following symptoms or conditions: (Please check if yes)

__ Epilepsy __ Drug Reactions __ Back, Neck, or Knee Problems __Diabetes __High Blood Pressure

__ Heart Disease or Heart Attack __ Chest Pains, Palpitations, or Heart Murmur __Have you had a stroke

__Do you have a history of Heart Disease, High Blood Pressure or Stroke in your family

If you checked any of the above, please explain each condition_____

_____

List any other conditions or recent injuries we should be aware of:_____

Name of Participating Group: _____

Signature of Participant: _____ Witness:_____

Parent/Guardian if participant is between 10 and 18:_____