**Personal Medical Form**

**Deer Hill Expeditions**

Name:

Age:

Height:

Weight:

Physician’s Name:

Physician’s Address:

Physician’s Phone:

Do you have a history of treatment for any of the following? If yes, please explain.

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | No |  |  | Yes | No |  |  | Yes | No |
| Respiratory Problems |  |  |  | Neurological Problems |  |  |  | Strains/Sprains/Fractures |  |  |
| Allergies |  |  |  | Seizure Disorder |  |  |  | Knee/Ankle Problems |  |  |
| Asthma |  |  |  | Gastrointestinal Problems |  |  |  | Back Problems |  |  |
| Do you smoke? |  |  |  | Dietary Concerns |  |  |  | Mental Health |  |  |
| Bleeding/Blood Disorder |  |  |  | Urinary/Reproductive Tract |  |  |  | Learning Disorder |  |  |
| Cardiac Problems |  |  |  | Menstrual Problems |  |  |  | Medications |  |  |
| Diabetes |  |  |  | Surgery |  |  |  | Others |  |  |

Explanations

Please list **all** current medications and their purpose

Date of last tetanus immunization

By signing:

1. I acknowledge that the health history provided is correct and true to the best of my knowledge.

2. I give permission to the medical personnel selected by Deer Hill, Inc. to order X-rays, routine tests, and treatment for myself, and, in the event I am unable to make coherent decisions, I hereby give permission to the physician selected by Deer Hill to hospitalize, secure proper treatment for, and to order injection(s) and/or anesthesia and/or surgery for myself.

3. This form may be copied for use out of camp.

Signature of Employee: Date: