

Birth Date _____ Name _____

Date attending NNREC program _____

Health Inventory for Adults

Contact Information

Home Phone _____ Work Phone _____ Mobile Phone _____

Address _____

City _____ State _____ Zip Code _____

Emergency contact: Name _____ Relationship _____

Home Phone _____ Work Phone _____ Mobile Phone _____

Family Doctor

Doctor's Name _____ Phone Number _____

Religious Preference _____

Insurance

The following insurance information is required if a doctor visit or entry into a hospital is necessary:

Do you have Health Insurance Coverage? YES NO

Name of Insurance Company _____

Address _____

Name Listed on the Insurance _____ Policy Number _____

Medications

Will you be taking prescription medication during the NNREC program? NO YES

Will you be bringing or taking over-the-counter medication during the NNREC program? NO YES

Health Conditions

	Yes		Yes		Yes
1. Asthma/inhaler		8. Diabetes		16. Recent illness or injury	
2. Life threatening reaction to bee stings or insect bites		9. Epilepsy/seizures		17. Recent exposure to contagious disease	
		10. Chronic illness			
3. Epi-pen		11. Depression		18. Car sickness	
4. Severe allergy to medication		12. Hearing problems		19. Sleepwalking	
5. Severe allergy to food		13. Vision problems			
6. Other severe allergies		14. Wear glasses/contacts			
7. ADD or ADHD		15. Eating disorders			

Please provide details for each checked box, being as specific as possible:

Are there other medical or social concerns that would assist us in providing a supportive and rewarding experience during the NNREC program? _____

Immunizations up to date? YES NO Date of last tetanus inoculation _____

List any DIETARY restrictions _____

Are you a vegetarian? YES NO

List any ACTIVITY restrictions _____

Authorization for Medical Treatment

I verify that this Health Inventory is correct and complete to the best of my ability. The person named above has permission to participate in all NNREC activities except as noted. I understand that I may walk as much as 5 miles a day and that exposure to natural features such as sun, wind, insects, and uneven walking surfaces will be encountered and are not under the control of NNREC.

For the duration of the NNREC program, I also give my permission to NNREC to provide routine first aid and care and to seek emergency medical treatment. I agree to the release of any records for insurance purposes. I give permission to NNREC to arrange necessary related transportation for treatment.

In the event of an emergency, I authorize the appropriate health care provider selected by NNREC to administer any necessary medical, surgical, and/or hospital care while the person named above is attending and/or en route to and from the NNREC program.

Signature

Date

If you do not want medical care given, do not sign above, and please briefly state your reason(s) below:
