

TEAMS & LEADERS

Advancing the practice of leadership

MEDICAL FORM

Every effort will be taken to assure your safety. To help us better understand your general physical health, and so that we can best assist you in the event that an injury does occur, we request the following information. The information you provide will be used solely for these purposes and will not be shared or distributed to others.

PART ONE: General Information

Today's Date: _____

Name:	Organization Name:	
Street Address:		
City/State/Zip:		
Email:		
Program Start Date:	Age:	
Male/Female (circle one)	Height:	Weight:
Home Phone:	Work Phone:	
Family Physician:	Phone:	
Emergency Contact:	Relationship to You:	
Home Phone:	Work Phone:	

PART TWO: Insurance

Are you covered by any hospitalization/medical care policy? Yes / No (circle one)

Insurance Company Name: _____ Policy # _____

Address: _____

Does your insurance company require pre-authorization? Yes / No (circle one)

If yes, phone: _____

Please Note: Each participant is responsible for any medical expenses and should be covered by her/his own sickness and accident insurance.

Continued on next page – signature required

Teams and Leaders MEDICAL FORM cont.

PART THREE: Medical History and Information

Please provide any information pertaining to your physical and/or mental health which could affect your participation in this program, or which may be needed should you require medical attention. **Please answer all questions** (note N/A where not applicable). Thank you.

Please describe your general physical fitness:

Any allergies? (e.g. bee stings, medications, pollen, food):

Medications-prescribed or otherwise? (Name, dosage and frequency, and reason for prescription):

Do you have any physical limitations that may prevent you from participating in the activities (past injuries, surgeries, etc.):

Is there anything about your physical condition, mental health, and/or medical history that we should be aware of? (asthma, cardiovascular disease, diabetes, seizures, fainting or dizziness, depression, etc.):

SIGNATURE REQUIRED

The information provided above is a complete and accurate statement of the physical and psychological factors which may affect my participation in the program. I realize the failure to disclose such information could result in serious harm to myself and fellow participants and agree to indemnify and hold Teams and Leaders, its employees and its representatives harmless if all relevant information is not disclosed. I also agree to notify Teams and Leaders and its representatives should there be any change in my health status prior to program start.

Signature

Date

Printed Name