



MEDICAL FORM

04170

PERSONAL INFORMATION

The information on this form is not part of the participant acceptance process, but rather is gathered to assist Campus Recreation in identifying appropriate care. Any changes to the information provided herein should be provided to *MaineBound* prior to the program, course, or activity for which the participant has registered. Please provide complete information so that *MaineBound* can be aware of your needs.

Name: _____ ID#: _____

Full Mailing Address: _____

Day Phone: _____ Night Phone: _____ Cell Phone: _____

E-Mail address: _____ Age: _____ Height: _____ Weight: _____

In event of emergency, notify: (Name) _____

Full Mailing Address: _____

Day Phone: _____ Night Phone: _____ Cell Phone: _____

E-Mail address: _____ Relationship: _____

MEDICAL INFORMATION AND HISTORY

Family Physician: _____ Phone: _____

List any medications to which you are allergic: _____

List any other allergies (food, plants, insects, etc.): _____

List nature of reactions to allergies: _____

List any illness or condition for which you are now under treatment: _____

List medications + reason for taking them: _____

If you have, or have had, any of the following, state year of occurrence:
Hernia _____ Fractures _____ Dislocations _____ Sprain/Strain _____

List any physical/medical disabilities of which MB should be aware:

HOSPITALIZATION

Date	Hospital	Nature of Hospitalization
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please complete the reverse side of this form and sign it

MEDICAL CONDITIONS

If you have, or have had, any of the following conditions, please circle "Y". If not, circle "N".

A.	Dizziness, loss of consciousness, recurrent headaches	Y	N
B.	Eye, ear, nose, throat, tonsils, or sinus problems	Y	N
C.	Impairment of sight, hearing, or speech	Y	N
D.	Chronic cough, coughing up blood, bronchitis, asthma, contact with tuberculosis	Y	N
E.	Chest pain, shortness of breath, palpitations, swollen ankles, heart murmur, heart disease, high or low blood pressure	Y	N
F.	Troublesome skin conditions - rash, infection, etc.	Y	N
G.	Symptoms related to gastrointestinal tract e.g., chronic diarrhea, ulcer, abdominal pain	Y	N
H.	Severe menstrual cramps or problems	Y	N
I.	Frequency in urination, bed wetting, diabetes	Y	N
J.	Muscle, joint, or back pain; arthritis, bursitis, sciatica	Y	N
K.	Benign or malignant growth or tumor	Y	N
L.	Episodes of depression, anxiety, hysteria, nervousness	Y	N
M.	Special dietary restrictions such as vegetarian	Y	N
N.	Frostbite, hypothermia, heat exhaustion, heatstroke	Y	N

Provide details for any questions in which you answered yes.

MaineBound reserves the right to request a Physician's examination of any participant prior to any program.

INSURANCE

Each participant must be covered by his/her own sickness or accident insurance, or sign a liability waiver through MaineBound. The University of Maine, Campus Recreation, and MaineBound do not provide sickness, health, or accident insurance.

Insurance Company: _____ Policy/Group No.: _____

My signature below indicates a desire on my part to participate in a MaineBound program or activity. I fully understand the rigorous nature of a MaineBound program. In the event of an emergency, permission is given for any medical treatment which might become necessary.

Participant Signature: _____ Date: _____

Parent/Guardian (If under age 18): _____ Date: _____