

Counselor/Teacher Name: \_\_\_\_\_

School: \_\_\_\_\_

**Mount Hermon Outdoor Science School**  
**Adult Health Emergency Information Form**  
**(All Adults over 18 Must Complete this Form)**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_\_ Female \_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Day/Evening Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Relation \_\_\_\_\_ Email \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_ Cell Phone/Pager \_\_\_\_\_

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**HEALTH INFORMATION** (Please fill out completely. No doctor signature is required. *Please explain* questions with an asterisk (\*) in space below. If an "In Past" is marked, please put a date next to it.)

**Medical Conditions**

- Bleeding/Clotting Disorder  Yes  No  In Past
- Asthma  Yes  No  In Past
- o Carry Inhaler  Yes  No  In Past
- Diabetes Type 1 ; 2   Yes  No  In Past
- Kidney Disease  Yes  No  In Past
- Heart Defects\*  Yes  No  In Past
- Hypertension  Yes  No  In Past
- Immune-Compromised  Yes  No  In Past
- Psychiatric Treatment  Yes  No  In Past
- Tuberculosis  Yes  No  In Past
- Bronchitis  Yes  No  In Past
- Seizures/Epilepsy  Yes  No  In Past
- Sleepwalking  Yes  No  In Past
- Other Medical Conditions\*  Yes  No  In Past
- Other Diseases\*  Yes  No  In Past

**Allergies**

- Hayfever  Yes  No  In Past
- Poison Oak  Yes  No  In Past
- Any Topical Application\*  Yes  No  In Past
- Medication Allergies\*  Yes  No  In Past
- Bees (state severity)\*  Yes  No  In Past
- Insects (state which)\*  Yes  No  In Past
- Nuts (state which)\*  Yes  No  In Past
- Latex  Yes  No  In Past
- Other\*  Yes  No  In Past
- o Carry Epi Pen for any?\*  Yes  No  In Past

Last Tetanus Shot  
Date \_\_\_\_\_ For what? \_\_\_\_\_

*\*Please explain severity* and/or any conditions, diseases or allergies marked "Yes" \_\_\_\_\_

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**HEALTH QUESTIONNAIRE:**

Are you taking regularly scheduled prescription medication?  Yes  No

Please list and explain all medications that you are taking (All medications, either Prescription or Over The Counter, have to be either on your person or held at the 1<sup>st</sup> Aid Station for you when you need it—*not* in the cabin.) \_\_\_\_\_

Are there any restrictions on your physical activity?  Yes  No

Please describe \_\_\_\_\_

Do you have any severe food allergies? Please list \_\_\_\_\_

Do you have any food restrictions (i.e. vegetarian/vegan/religious) or moderate food allergies? Please list \_\_\_\_\_

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_