Kent Mountain Adventure Center, Inc.
P.O. Box 835
Estes Park, CO 80517
(970) 586-5990

Participant Medical Form

COMPLETED FORM IS REQUIRED

Participant Name: _____ Age: ____ Date of birth: _____/_____/_____

Address/P.O. Box: _____

City: _____ State: _____ ZIP: _____

Participant Email:_____

Name of Course: Environmental Education in the Rockies NRRT 365

M _____ F _____ Height: _____ Weight: _____ Last physical exam: _____/_____/_____

Dates of immunizations: Tetanus: _____ Polio: _____ Measles: _____

Please include a copy of the participant's latest medical physical including immunizations.

Emergency Contact Name: _____Relation: _____

Day phone: (_____)_____ Night phone: (_____)_____

If above party cannot be reached, please contact: (list two individuals):

1. Name: _____

Relationship to participant: _____

Home phone: (_____)_____

Business phone: (_____)_____

2. Name: _____

Relationship to participant: _____

Home phone: (_____)_____

Business phone: (_____)_____

List any chemical or drug allergies (penicillin, sulpha, iodine, etc.): _____

_____

List any allergies: food (nuts, fish, peanut butter, dairy, etc.), insects (bee stings, etc.), hayfever (pollen, mold, etc.):
_____

_____

Has participant ever been stung by a bee/wasp: Yes ❑ No ❑

Has participant experienced any dizziness, fainting, epilepsy, asthma, sleep walking:

The following may be given if deemed necessary to relieve minor pain and discomfort:

Tylenol	Yes ❑ No ❑	Ibuprofen	Yes ❑ No ❑
Immodium for diarrhea	Yes ❑ No ❑	ExLax for constipation	Yes ❑ No ❑
Decongestant	Yes ❑ No ❑	Antihistamine	Yes ❑ No ❑
Antacid for indigestion	Yes ❑ No ❑	Throat lozenges	Yes ❑ No ❑

List all medications participant is currently taking:

Name of med.: _____ Name of med.: _____

Dosage: _____ Dosage: _____

Times given: _____ Times given: _____

Date medication started: _____ Date medication started: _____

Reason for medication: _____ Reason for medication: _____

Special diet?: _____

Does the participant have any pre-existing medical conditions?: _____

_____

Past history of injuries (include dates): _____

_____

Additional comments (use a separate sheet if necessary): _____

I hereby give my permission to the physician selected to hospitalize and secure proper treatment for me including emergency care.

Signature of participant: _____ Date: _____

Signature of parent/guardian (if under 18): _____ Date: _____

Participant's Doctor: _____ Phone: (_____)_____

Doctor's address: _____

Medical Health Insurance: Company: _____

Address: _____

Policy #: _____ Group #: _____ Phone: (_____)_____

If there are any changes in the participant's medical status between now and the course departure, please contact KMAC with the new information as soon as possible (970) 586-5990.