

BABES IN THE BACKCOUNTRY
Medical Form

The following medical information may help you in the event of an accident. Please complete this form as accurately and truthfully as possible. The facts you disclose will be confidential and will only be used to help Babes in the Backcountry staff and others respond to an injury. This form is to be used in conjunction with the Babes in the Backcountry Participation Agreement. The Activity as defined therein in the Activity for which you, the participant, are disclosing this information. **Please print clearly, and complete all portions of this form.**

PARTICIPANT INFORMATION

Name: _____ (please print clearly)
Address: _____ (address, line 1)
 _____ (address, line 2)
 _____ (city, state, zip code)
Telephone #: _____ (cell/home/work/other) (circle)
Telephone #: _____ (cell/home/work/other) (circle)
Email: _____
Date of Birth: _____/_____/_____ Age: _____ Gender: Babe/Not Babe (circle)
Weight: _____ Height: _____ Blood Type: _____

INSURANCE INFORMATION

Are you covered by a medical insurance policy: Yes/No (circle) Company's Telephone #: _____
Medical Insurance Policy Carrier: _____
Policy Holder Name: _____ Policy #: _____ Group #: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Relationship: _____
Address: _____ (address, line 1)
 _____ (address, line 2)
 _____ (city, state, zip code)
Telephone #: _____ (cell/home/work/other) (circle)
Telephone #: _____ (cell/home/work/other) (circle)
Email: _____

DOCTOR CONTACT INFORMATION

Name: _____
Address: _____ (address, line 1)
 _____ (address, line 2)
 _____ (city, state, zip code)
Telephone #: _____

This form is two-sided. Please fill out the other side of this form.

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Date of last physical exam: _____

Are you certified in first aid? Yes/No
Do you wear corrective lenses? Yes/No
Do you have problems hearing? Yes/No
Do you have dentures or false teeth? Yes/No
Can you swim? Yes/No
Are you pregnant? Yes/No

Do you have any fears or phobias? Yes/No If yes, describe:

Are you under treatment for a medical condition? Yes/No If yes, describe:

Are you taking any medication? Yes/No If yes, name, dosage, and frequency:

Do you have any allergies? Yes/No If yes, please list and describe reaction:

If yes, do you take medication for it? Yes/No If yes, please list:

If yes, do you have your medication with you? Yes/No If yes, where:

Do you have any past injuries? Yes/No If yes, describe:

Have you every undergone surgery? Yes/No If yes, describe:

Have you ever had issues with altitude? Yes/No If yes, describe:

Please check off any of the following illnesses, injuries, or conditions you have or have had and give the year of the occurrence:

- | | | | | | |
|-----------------------------------------|-------------------------------------------------|----------------------------------------|------------------------------------------------|--------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Frostbite | <input type="checkbox"/> Hypothermia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Concussion | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Dislocation |
| <input type="checkbox"/> Sprains | <input type="checkbox"/> Frequent muscle cramps | <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | | <input type="checkbox"/> Headaches/migraines |
| <input type="checkbox"/> Bone fractures | <input type="checkbox"/> Hernia | <input type="checkbox"/> Obesity | <input type="checkbox"/> Cardiovascular issues | | <input type="checkbox"/> Hemophilia |

Do you have any medical conditions that are not noted above? Yes/No. If yes please describe:

The Activity requires vigorous physical and mental exertion, possibly in isolated areas without medical facilities, medical providers, or means of contacting medical or rescue personnel. Please describe any information, medical or otherwise, of which BIB should be aware that is not noted above that may be significant under these circumstances:

Physician's Report: A physician's approval may be required for your participation in this course. Furthermore, you may wish to consult a physician prior to undertaking the Activity, especially if you have any questions concerning your fitness for purposes of participating in the Activity. BIB will be happy to answer any questions your physician may have in regard to the Activity.

Do you authorize use of your credit card in the event of medical emergency care? Yes/No. If yes, card type: Amex/MC/Visa

Card #: _____ Exp. Date: _____

I _____(name) agree to pay for all medical expenses incurred in the event of medical emergency.

If, in the opinion of a properly licensed and practicing physician, I need medical or surgical services which require my authorization before being supplied, I hereby authorize, appoint, and empower BIB to act as my agent to furnish on my behalf such oral or written authorization as may so be required, and to release any records necessary for insurance purposes; and to provide or arrange necessary or related transportation for me. I hereby give permission to the physician selected by BIB to secure and administer treatment, including hospitalization, for me. I release BIB from any liability which might arise from the giving of such authorization, it being my desire that I be furnished with such medical or surgical services as soon as reasonably possible after the need arises.

Signature: _____

Date: _____/_____/_____

****Babes in the Backcountry requires full disclosure of all medical conditions. Babes in the Backcountry reserves the right to limit course participation due to medical conditions****