

CORE MEDICAL INFORMATION

FIRST NAME: _____ LAST NAME: _____ CUID _____

CURRENT HEALTH ISSUES: Please include any items that you feel your trip leader should be aware of. None

Item#	Detailed description: (include allergies, recent surgeries, injuries, etc...)

DIETARY RESTRICTIONS: (Vegetarian, vegan lactose intolerant, kosher, etc. Please indicate specific restrictions). None

HEALTH INSURANCE INFORMATION:

Participants must carry personal health/medical insurance. CORE does not provide this type of insurance for participants.

Health Insurance: _____ Policy Holder: _____ Policy #: _____

EMERGENCY CONTACT INFORMATION:

PARTICIPANT CONTACT INFORMATION:

ID#: _____

Campus Address: _____ City: _____ State: _____ Zip: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Campus Phone: () _____ Home Phone: () _____ Email: _____

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT:

Emergency Contact's Name: _____ Relationship: _____

Daytime Phone: () _____ Evening Phone: () _____

Emergency Contact's Name: _____ Relationship: _____

Daytime Phone: () _____ Evening Phone: () _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I, _____, give consent for any **emergency** hospitalization, anesthesia, operation, field evacuation or other medical treatment which might become necessary while participating in this activity.

Signature: _____ Date: _____

Parent/Guardian Signature (under 18): _____ Date: _____