CONFIDENTIAL MEDICAL FORM

Provide complete answers to all questions

GENERAL INFORMATION: Workshop Title: Leave No TraceTrainer Course **Workshop Date**: September 15-16th, 2022

Name: _____ DOB (if under 18): _____

EMERGENCY CONTACT: (Parent or guardian information if participant is under 18):

Name: _____ Relationship: _____ e-mail: _____

Phone #: Day (____)_____ Evening (____)_____ Cell/Page (____)_____

Address: _____
Street *City* *State* *Zip*

INSURANCE COVERAGE: Participant is responsible for his or her own medical expenses. Insurance is recommended, but not required for participation. The information requested below is for the **primary family policy holder**.

Insurance Company: _____ Insurance Company Phone #: (____)_____

Certificate/Policy/ID #: _____ Group # (if applicable): _____

Address: _____
Street *City* *State* *Zip*

Name of Policy Holder: _____ Soc. Security #: _____

Phone #: _____ Place of Employment _____

Address: _____
Street *City* *State* *Zip*

Physician/Primary Care Provider's Name: _____ Phone #: (_____)_____

ALLERGY INFORMATION: Please list all known (bites, stings, food, medications, plants, and animals)

Allergy	*Reaction*	*Medication Required*

Are there any physical or medical conditions not listed above which may affect or limit participation?

❒ Yes ❒ No

If yes, please explain (attach additional sheets as necessary):

_____

_____

_____

PLEASE READ CAREFULLY :

- Please review this form to be certain you have completed every question. This complete Medical Form is required for participation in this Leave No Trace program.
- All information on this form is confidential. It is possible to complete many Leave No Trace programs with a variety of medical/psychological difficulties, but the Appalachian Trail Conservancy must be aware of these conditions. Failure to disclose medical and health history information as requested could result in serious harm to you and other participants in your program.

SIGNATURE REQUIRED

Consent is hereby given for the applicant to attend a Leave No Trace course. Permission is given for Appalachian Trail Conservancy, staff, volunteers, representatives, or contractors to obtain or provide medical care for me/my child, or to transport me/my child to a medical facility. I further authorize the Appalachian Trail Conservancy staff, volunteers, or other medical personnel to render such treatment they consider necessary for my/my child's health, and I agree to pay all costs associated with that care and transportation. I have read and understand both sides of this medical form and the information I have provided is, to t best of my knowledge, correct and complete.

_____ _____

Applicant's signature Date

_____ _____

Signature of parent/guardian (if applicant is under 18) Date