

Catalyst Adventures

Medical History Form

Personal Information

Name _____ Age _____

Address _____ Phone _____

City _____ State _____ Zip _____

Email _____

Emergency Contact person _____ phone _____ / _____

Medical Insurance Co. _____ Policy # _____

Medical History:

- Past or current medical conditions relevant to this activity (ie asthma, heart conditions, etc...) _____

- Allergies _____

- Have you ever had an allergic reaction to bee stings? _____ When? _____

- Have you ever had a serious heart condition? _____ please describe _____

- Have you had surgery in the past year that would affect your ability to complete this activity? _____ Please describe _____

- Are you currently on medication? _____ please describe _____
_____ If necessary, do you have meds with you? _____

Signature X _____ date _____

