BELIZE MISSION AND RETREAT
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CONFIDENTIAL MEDICAL HISTORY

PLEASE PROVIDE THE FOLLOWING INFORMATION. ALL AREAS NEED TO BE COMPLETED.

PERSONAL INFORMATION:

NAME OF APPLICANT:____

EMERGENCY CONTACT

FIRST
NAME: ______________________
RELATIONSHIP:_____________________
DAY PHONE:_______________________
HOME/EVE PHONE:__________________

SECOND:
NAME: ______________________
RELATIONSHIP:_____________________
DAY PHONE:_______________________
HOME/EVE PHONE:__________________

ADDITIONAL INFORMATION:____
____

MEDICAL COVERAGE:

PHYSICIAN'S NAME:_____________________ PHONE NUMBER:______________
ARE YOU COVERED BY MEDICAL INSURANCE? ☐ YES ☐ NO
NAME OF INSURANCE COMPANY:__________________________________
POLICY #:______________________ GROUP #:____________________
ADDRESS OF INSURANCE COMPANY:_______________________________
____

PLEASE STAPLE A PHOTOCOPY (FRONT AND BACK) OF YOUR MEDICAL INSURANCE CARDS TO THIS FORM

PRE-EXISTING CONDITIONS/ILLNESSES:

	YES	NO
Asthma	☐	☐
Respiratory/Emphysema	☐	☐
Bleeding Gums	☐	☐
Colitis	☐	☐
Epilepsy (seizures)	☐	☐
Heart Disorder	☐	☐
Psychiatric Disorder	☐	☐
Alcoholism/Drug Use	☐	☐
Diabetes	☐	☐
High Blood Pressure	☐	☐
Hepatitis/Infectious Disease	☐	☐
Migraine Headaches	☐	☐
Kidneys	☐	☐
Ulcers	☐	☐
Cancer	☐	☐
HIV/AIDS	☐	☐

DATE OF LAST TETANUS: ____________ DATE OF LAST HEPATITIS: "A" ________ B"_________

OTHER PRE-EXISTING CONDITIONS OR ILLNESSES OR EXPLANATION OF ANY "YES" ANSWERS ABOVE:
____
____

INJURIES:

	YES		NO		YES		NO
Head Injury	☐	Date:__________	☐	Recurrent Ankle Injury	☐	Date:__________	☐
Back Injury	☐	Date:__________	☐	Recurrent Knee Injury	☐	Date:__________	☐
Broken Bones	☐	Date:__________	☐	Other:_______________	☐	Date:__________	☐

List Broken Bones, if any:____

MEDICATIONS:

Please list all medications you are currently taking:

NAME	DOSE	FREQUENCY
____________________	________________	______________________
____________________	________________	______________________
____________________	________________	______________________

Please explain the condition you are treating with medication:____________________

____

ALLERGIC REACTIONS:

Do you have any allergies, including reactions to food, penicillin, antibiotics, or any other medications? ☐ YES ☐ NO

Please explain:____

____

Do you carry a personal epi-kit in case of an allergic emergency? ☐ YES ☐ NO

DIETARY NEEDS:

Do you have special dietary needs? ☐ YES ☐ NO

Are you a vegetarian? ☐ YES ☐ NO

If yes, please specify or describe the need (i.e., vegan, no dairy, no red meat, etc.):______

____

SPECIAL NEEDS:

Do you have any physical, mental, or emotional conditions which would limit your full participation or that we should be made aware of? ☐ YES ☐ NO

If yes, please describe:____

____

____

*SIGNATURE:*_________________________________*DATE:*____________