MEDICAL INFORMATION FORM
Hawai`i Service Trip Program of the Sierra Club, Hawai`i Chapter

Name: _____ Trip Name and Year: _____
Address: _____
City, State: _____ZIP: _____
Daytime Phone: _____ Evening Phone_____
Gender: _____ Birth Date: _____ Height: _____Weight: _____
Color Hair: _____Color Eyes: _____
Allergies: _____
Recent Illnesses: _____
Operations, serious accidents:
Current Medications:
Please note if you have had an occurrence of any of the following:

YES	NO	
®	®	Asthma
®	®	Diabetes
®	®	Pneumonia
®	®	Anemia
®	®	Tuberculosis
®	®	Epilepsy
®	®	Other lung disorder
®	®	Mental illness
®	®	Heart disorder
®	®	Other chronic illness

If you checked YES for any of the above, please explain present condition on a separate sheet.
Ability to do moderately strenuous physical work: _____
Do you have an unreasonable or undue fear of heights or exposed places? ___
Are you allergic to any medication, or suffer from harmful side effects with particular medications? _____
If so, please indicate which medication(s): _____
In the event of an emergency, notify: _____Relation: _____
Address (if different from above): _____
City, State: _____ZIP: _____
Daytime Phone: _____ Evening Phone: _____
To the best of my knowledge, the above information is correct and current.

Signature of trip applicant: _____Date: _____

Signature of Parent/Guardian: _____Date: _____
(If applicant is under 18 years of age)

(FORM CONTINUES ON NEXT PAGE)

NOTICE: The following is required. Applicants or participants will not be accepted without it:

I AUTHORIZE THE TRIP LEADER(S) TO GIVE OR ARRANGE FOR ALL NECESSARY MEDICAL CARE FOR THE PARTICIPANT IN CASE OF ILLNESS OR INJURY WHILE ON THIS TRIP. I UNDERSTAND THAT MEDICAL EXPENSES INCURRED DURING THE TRIP ARE THE RESPONSIBILITY OF THE PARTICIPANT. IN SIGNING BELOW, I ACKNOWLEDGE ON BEHALF OF THE PARTICIPANT AND/OR THEIR GUARDIAN THAT I UNDERSTAND AND WILL COMPLY WITH THE ABOVE STATEMENTS.

Signature of applicant: _____ Date: _____
Signature of Parent/Guardian: _____Date: _____
(If applicant is under 18 years of age)
I HAVE MY OWN HEALTH INSURANCE (YES/NO): _____
If YES, Insurance Provider and Policy Number: _____

Name of insured (if other than applicant): _____

PLEASE FOLLOW THE INSTRUCTIONS CHECKED BELOW:

® You are new to the Hawai`I Service Trip Program or we have no record of a recent physical examination on file. You are required to complete this, get a physical examination, and procure the examining physician's signature where indicated below.

® We have your recent physical examination report on file. You must complete the medical information portion of this form (page one) for our files, and sign the treatment authorization and medical expense statement of responsibility which is printed directly above.

IF AN EXAMINATION IS REQUIRED, COMPLETE THE FOLLOWING:

Name of Physician: _____
Date of examination: _____
Physician's Office Address: _____ ZIP _____
Physician's Phone: _____
I find the examined person to be able to perform reasonably strenuous physical activities and work.
Signature of Physician: _____ Date: _____

NOTICE: As the danger of tetanus is high in accidents occurring in backcountry areas, participants are requested to consult with their physicians regarding the advisability of anti-tetanus inoculations or booster shots as appropriate. Your physician may also recommend other immunization.