MEDICAL INFORMATION FORM

Full name: _____ Nickname: _____
Campus address: _____
Campus phone: _____ Email: _____
Medical insurance provider and phone number: _____
Policy Number: _____ Date effective: _____ Expiration Date: _____

Please assess your current activity level:

Briefly summarize your previous outdoor experience:

_____
_____
_____

Do you have any allergies? Write “no allergies” if none.

Allergen:	Please detail reaction to allergen: