

**ADOPTION TOUR
Participant Medical Form**

NAME _____ **AGE** _____ **Gender** _____

ADDRESS _____ **City** _____

PHONE _____

PAST ILLNESS:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer (Site _____) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Problem | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Blood Problems | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Abnormal Heart Rhythm | |

ALLERGIES: **NONE** **Bee/Wasp Sting** **Poison Ivy/Oak**

MEDS _____ **FOODS** _____

OTHER _____

CURRENT MEDICATIONS None _____

CURRENT/CHRONIC MEDICAL CONDITIONS None _____

PERSONAL PHYSICIAN _____

ADDRESS _____ **PHONE** _____

MEDICAL INSURANCE COMPANY _____

POLICY NO. _____ **ID NO.** _____

EMERGENCY CONTACT _____ **PHONE** _____

EMERGEMCY CONTACT _____ **PHONE** _____

The information provided is accurate to the best of my knowledge.

Signature _____ **DATE** _____