FOOTHILL HORIZONS OUTDOOR SCHOOL
ADULT HEALTH FORM

Name_____ Date Of Birth_____

School_____ District_____

Address _____
Street City Zip

Cell (____) _____ Cell (____) _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name:_____ Relation:_____ Phone:_____

Name:_____ Relation:_____ Phone:_____

HEALTH INFORMATION

YES **NO**

❒ ❒ 1. Do you have any **health concerns** (heart condition, diabetes, high blood pressure)

_____

_____

❒ ❒ 2. Do you have any **serious allergies** to foods, insect stings, medications, or other substances?
If YES, what are you allergic to?

_____

Is this allergy life threatening? ❒ Yes ❒ No **Epi Pen needed?** ❒ Yes ❒ No
Is this allergy from: ❒ Contact/touch ❒ Ingestion/eating ❒ Airborne/inhalation

❒ ❒ 3. Are there foods you CANNOT eat? (e.g. Vegetarian, no beef) ❒ no beef ❒ no pork ❒ vegetarian
❒ vegan ❒ other _____

❒ ❒ 4. Do you take any medication? If yes, please list: _____

Physician: _____ _____
(If none, state "None") Phone #

Insurance Carrier: _____ ID # _____

I herby consent to emergency treatment if the need arises.

_____ _____
Signature Date

REV: 7/24/2018