Name: _____ Birth Date: _____

Dates Attending GBOS: _____

Emergency Information: Adult

Contact Information

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Email: _____

Emergency Contact Information

Name: _____ Relationship:_____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Address: _____ Email: _____

Family Doctor

Doctor's Name:_____ Phone Number: _____

Insurance

The following insurance information is required if a doctor visit or entry into a hospital is necessary.

Do you have Health Insurance Coverage? YES NO

Name of Insurance Company: _____

Address: _____

Name Listed on the Insurance: _____ Policy Number:_____

Medications

Will you take **prescription or over-the-counter medication** while at GBOS? YES NO
If so, please list below so that in the event of an emergency resulting in unconsciousness or impaired memory, we will be able to respond to attending physician's inquiries on what you may have been taking. Medications will be stored in a secure area, and will be self-administered by the adult.

Health Conditions

	YES		YES		YES
1. Asthma/Inhaler		7. Diabetes		13. Recent Illness or Injury	
2. Life Threatening Reaction To Bee Stings or Insect Bites		8. Epilepsy/Seizures		14. Recent Exposure to Contagious Disease	
3. Epi-Pen		9. Chronic Illness		15. Car Sickness	
4. Severe Allergy to Medication		10.Hearing Problems		16. Sleep Walking	
5. Severe Food Allergy		11. Vision Problems		17. Wear Glasses/Contacts	
6. Other Severe Allergies		12.Food Intolerances			

Please provide details for each checked box, being as specific as possible:

\# Details

____ _____
____ _____
____ _____
____ _____
____ _____
____ _____

Are immunizations up to date? YES NO Date of last Tetanus Inoculation: _____

Are you a vegetarian? YES NO

List any DIETARY restrictions: _____
List any ACTIVITY restrictions: _____

Authorization for Medical Treatment

I verify that this Emergency Information is correct and complete to the best of my ability. I understand that I may walk as much as 5 miles a day and that exposure to natural features such as sun, wind, insects, and uneven walking surfaces will be encountered and are not under the control of GBOS.

For the duration of the GBOS program, I also give my permission to GBOS to provide routine first aid and care and to seek emergency medical treatment if needed. I agree to the release of any records for insurance purposes. I give permission to GBOS to arrange necessary transportation for treatment. In the event of an emergency, I authorize the appropriate health care provider selected by GBOS to administer any necessary medical, surgical, and/or hospital care while I am attending and/or en route to and from the Great Basin Outdoor School.

Signature: _____Date_____

If you do NOT want medical care given, do not sign above and please briefly state your reason(s) below.

_____