Family Name:

Emergency Information and Medical Certification

Personal Information:

Full Name: _____ Date of Birth: _____

Field Activity: _____ Dates: _____

The following information may be critical to caring for you in case of an injury or sudden illness during the Activity. It will be used **only in the event of an emergency**, and only if you are unable to communicate this information to those treating you. This form will be destroyed at the conclusion of the Field Activity.

Personal Health/Accident Insurance:

Company: _____ Policy/ID Number: _____

Known Dangerous Allergies (please list): (e.g. medicine, food, plant, animal, insect toxin):

_____

Miscellaneous:

I normally wear/use: ☐ Contact Lenses ☐ Dentures ☐ Other (list):

_____

I hereby authorize release of the information herein to medical personnel in case of emergency:

Signature : _____ ***Date:*** _____

Name (printed): _____

Stop here unless one or more of the Medical Conditions below applies to you.

Medical Certification:

Please provide any information you wish regarding medical condition currently requiring special care, medication, or diet that can adversely affect or limit personal health or safety in the activities described in the overview letter. These may include, but not be limited to: (limited mobility/hearing/sight, fear of heights, dangerous allergies, medical conditions other than those listed below, and pregnancy).*

_____

_____

_____

_____

☐ The following conditions require a licensed physician or nurse practitioner to certify your fitness to participate in the Activity:

- ☐ Asthma
- ☐ Bleeding disorders
- ☐ Convulsions/seizures
- ☐ Diabetes
- ☐ Fainting Spells
- ☐ Heart Trouble
- ☐ High blood pressure

**Please consult your organization's Medical and Occupational Health group if you have any questions.*

Health-care provider's statement: ***I have examined this patient and certify that the existence of the conditions checked above do not prohibit him/her from participating in the activities described in the Pre-Activity Safety Assessment.***

Signature : _____ ***Date:*** _____

Name (printed): _____

Family Name:

Emergency Information and Medical Certification

Background Information: Please provide the following information to assist the Activity Staff in making preparations for the Field Work.

Dietary Restrictions:

Do you require any modifications to the Activity methods or activities (as described in Pre-Trip letter) to participate? (due to, for example, limited mobility/hearing/sight, fear of heights, plant or insect allergies, medical conditions (heart trouble, breathing problems, diabetes, etc.), pregnancy, etc.). Do you require any special emergency response preparations (e.g., medications requiring cold storage)?

☐ No ☐ Yes (specify below)

What Safety, Health, and Environmental training do you have:

	Subject	Course Name	Date of Completion
☐	First Aid		
☐	CPR		
☐	AED		
☐	Defensive Driving		
	Experience with driving large 4WD SUVs?	years; Locations:	
☐	Water/Small Craft Safety		
☐	Other		

Briefly describe your relevant experience in field activities:

Contact the following people in the event that I cannot communicate with them myself:

Emergency Personal Contact:

Name: _____ Relationship: _____

Telephone: Day: _____ Evening: _____ Mobile: _____

Alternate Personal Contact:

Name: _____ Relationship: _____

Telephone: Day: _____ Evening: _____ Mobile: _____

Organization Contacts:

☐ **DO NOT contact my home organization in the event of an emergency**

Organization Unit: _____ City: _____

Emergency Contact (name): _____ Position: _____

Telephone - Day: _____ Evening: _____ Email: _____

Alternate Organization Contact:

Emergency Contact (name): _____ Position: _____

Telephone - Day: _____ Evening: _____ Email: _____