



# MEDICAL HISTORY FORM

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**\*ALL ITEMS MUST BE FILLED OUT BY A PARENT/GUARDIAN.  
NO ONE WILL BE ALLOWED TO PARTICIPATE IN A FLOC OUTDOORS PROGRAM WITHOUT A  
COMPLETED MEDICAL FORM ON FILE.**

Fellow Name: \_\_\_\_\_ Parent or Guardian Signature: \_\_\_\_\_

**I authorize a trained FLOC Outdoors staff member to administer the following over-the-counter medications (i.e. for a headache or stomachache, etc.) to the participant. Please check all you allow:**

Tylenol     
  Ibuprofen     
  Pepto bismol     
  Anti-Diarrhea

**General Questions (You MUST explain “yes” answers below)**

**Has/does the participant:**

	Yes	No
1. Had any recent injury, illness, or infectious disease.		
2. Have a chronic or recurring illness/condition?		
3. Take medication (prescribed or over the counter)?		
4. Ever been hospitalized?		
5. Ever had surgery?		
6. Have any emergency allergic reactions (e.g., bee stings, food, etc.)?		
7. Have frequent headaches?		
8. Ever had head injury?		
9. Ever been knocked unconscious?		
10. Ever had frequent ear infections?		
11. Ever passed out during or after exercise?		
12. Ever had seizures?		
13. Ever had chest pain during or after exercise?		
14. Ever had high blood pressure?		
15. Ever been diagnosed with a heart murmur, or other heart conditions?		
16. Ever had back problems?		
17. Ever had problems with joints (e.g., knees, ankles, etc.)?		
18. Have any skin problems (e.g., itching, rash, acne, etc.)?		
19. Have diabetes?		
20. Have asthma?		
21. Had mononucleosis in the past 12 months?		
22. Had problems with diarrhea/constipation?		
23. If female, have an abnormal menstrual history?		
24. Have a history of bed-wetting?		
25. Have any dietary restrictions (e.g., seafood, pork, vegetarian, etc.)?		
26. Have problems with sleepwalking?		

Please explain any “Yes” answers, noting the number of the questions. Use the back if needed.

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