

MEDICAL HISTORY QUESTIONNAIRE

Name _____

Date of Birth _____ Sex: _____

Address _____

City/State/Zip: _____

Medical Ins. Co.: _____ Policy #: _____

Emergency Contact: _____ Phone: _____

Physician: _____ Phone: _____

NOTE: Please check "yes" or "no" and provide additional details where required.

ALL INFORMATION WILL BE HELD CONFIDENTIAL

1. Are you allergic to any foods? No__ Yes__ List Foods: _____

2. Are you allergic to any medication? No__ Yes__ List Medication: _____

3. Are you currently taking medication? No__ Yes__ List Medication: _____

4. Do you have, or have you ever had the following:

Hay fever: No__ Yes__

Fainting Spells: No__ Yes__

High Blood Pressure: No__ Yes__

Diabetes: No__ Yes__

Asthma: No__ Yes__ List Medication: _____

Seizures: No__ Yes__

Heart disease: No__ Yes__

Lung disease (emphysema, etc.): No__ Yes__

Liver disease (mononucleosis, etc.): No__ Yes__

Hepatitis: No__ Yes__

Urinary infection: No__ Yes__

5. Have you ever had a hernia or rupture? No__ Yes__

6. Have you ever had a concussion or head injury? No__ Yes__ When: _____

7. Date of last tetanus inoculation _____

THIS MEDICAL HISTORY QUESTIONNAIRE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Signature of Participant _____ Date _____

EMERGENCY MEDICAL AUTHORIZATION

The attached health history is correct to the best of my knowledge, and I am able to engage in all activities, except as specifically noted by me and a physician . In the event of an emergency, I hereby give permission to a physician to hospitalize, secure proper anesthesia, or to order injection or surgery, or other medical procedures required in an emergency situation.

I give consent for the Massachusetts Division Of Fisheries & Wildlife (hereinafter MDFW), to provide medical attention, transportation, and emergency medical services as warranted by the circumstances.

I am in good physical condition, and am not aware of any disease or injury that would be aggravated or result in my being incapacitated or injured during any program participation except as signed herein.

Signature of Participant _____ Date _____

LIABILITY/MEDICAL RELEASE

If I am injured or suffer any illness or disease while residing at and/or participating in programs of the MDFW, except as may be caused by the grossly negligent or reckless conduct of the MDFW and their agents, employees and volunteers, I agree to hold MDFW harmless for any said injury, illness, or disease.

I further understand and agree to abide to the general rules of conduct prescribed for the guests of **MDFW**, and violations may result in a denial of privileges, a forfeiture of all fees paid, and immediate removal from **MDFW** property.

I HAVE READ THIS RELEASE. I UNDERSTAND THAT IT AFFECTS LEGAL RIGHTS AND RESPONSIBILITIES, AND I HEREBY AGREE AND CONSENT TO ITS TERMS AND CONDITIONS AND HEREBY WAIVE ANY CLAIMS ARISING WHILE RESIDING AND/OR PARTICIPATING IN THE PROGRAMS OF THE MDFW.

Signature of Participant _____ Date _____