NORTHERN LIGHTS RESORT & SPA

MEDICAL AND PERSONAL FORM

Please complete this form to the best of your ability as it is in your own best interest that this documentation is available in any kind of medical emergency. Your information will be kept confidential and will not be released to third parties except medical personnel in case of emergency.

PERSONAL INFORMATION

Participants Name ____ Date ______________________

Age ____________ Sex ____________ Height _____________ Weight __________

In case of emergency call (name and phone) ____

Evaluate your health: ___Fair ___Good ___Excellent

Evaluate your physical conditions: ___Below Average ___Average ___Above Average ___Excellent

MEDICAL INFORMATION

Has there been any change in your general health the past year? ___Yes ___No

Please explain ____

Are you now under the care of a physician? ___Yes ___No

Please explain ____

Have you had any serious illness, injury or operations? ___Yes ___No

Please explain ____

Do you have or have you had any of the following diseases or problems:

- Allergies (If so, to what?____) ___Yes ___No
- Arthritis ___Yes ___No
- Asthma or hay fever ___Yes ___No
- Cardiovascular disease: heart trouble, heart attack ___Yes ___No
- Coronary insufficiency, arteriosclerosis, stroke ___Yes ___No
- High blood pressure ___Yes ___No
- Inflammatory rheumatism ___Yes ___No
- Tendonitis, Tenosinovitis or Carpal Tunnel syndrome ___Yes ___No
- Women: are you pregnant?
- Others (If so, to what?____) ___Yes ___No

Are you allergic:

- Do you have any food allergies? (Please explain) ___Yes ___No

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List any special dietary requirements: ___Yes ___No

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14. Do you have any disease, condition, or problems not listed above, that you think we (or in case of emergency a doctor) should know about?

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