Thom Stecher and Associates Inc.
Experiential Dynamics Inc.
Medical Information Form

Please Print

Participant Medical Information

1. Name: _____
2. Date of Birth: _____
3. Emergency Contact: (Name, Address and Phone Number) _____
_____
4. What is your current level of physical activity? Explain _____
_____

Medical History

1. Do you have any allergic reactions? (e.g. Bees, Drugs, Food, Etc.) _____
Please specify: _____
Have you ever been stung by a bee or wasp? Yes ___ No ___
2. Are you currently taking any medications? _____ If so, what? _____
_____
3. Do you have any chronic illnesses? (e.g. Diabetes, Epilepsy, Asthma, Etc.) _____
If so, what?_____
4. Do you have any physical conditions that might prevent you from participating in any physical activities? _____ If so, please explain: _____
_____
5. Have you experienced any injuries within the last three years? (e.g. Dislocations, Severe Sprains, Torn Ligaments, Separations, Etc.) _____
If so, please state when the injuries occurred, the extent and severity of the injury and if you have fully recovered from this injury. _____
_____
6. Are you currently being treated by a physician? _____
If so, please explain: _____
_____
7. Do you have any physical disabilities? _____ If so, please explain: _____
_____
8. Do you wear contact lenses? _____
9. Have you had a tetanus shot within the last three years? _____
10. Family Doctor's Name Address and Phone Number: _____
_____
11. Any additional medical information you feel would be of value to the facilitator of the group session: _____
_____

PARTICPANT'S SIGNATURE: _____