



Medical Treatment Authorization

IN CASE OF MEDICAL EMERGENCY, I _____ hereby authorize Core Angling faculty and staff, or its employees or agents to secure appropriate medical treatment for me. I authorize the healthcare professionals in attendance to secure and/or administer proper medical treatment for me. This may include (but not be limited to): injections, anesthesia, surgery and hospitalization. I agree to be responsible for the cost of any and all medical treatment and all other services provided to me incurred during my treatment and to indemnify Core Angling for any costs incurred on account of my medical treatment

Witness Signature

Participant Signature

Date _____

DIVERS ALERT NETWORK “BASIC MEMBERSHIP” Is included for all participants

<http://www.diversalertnetwork.org/>

24-Hour DAN TravelAssist

"As a DAN Member, you automatically receive DAN TravelAssist and up to \$100,000 of evacuation assistance coverage. Effective for both diving and non-diving injuries, this benefit is provided by MedAire, a world leader in emergency evacuation services. Your evacuation coverage begins when you are traveling at least 50 miles/80 km from home and call DAN TravelAssist to arrange your evacuation."

Visitor Medical History Form

Participant Name: _____

Current Address: _____

Telephone #: _____

Fax: _____

Email Address: _____

Current Physician: _____

Telephone #: _____

Persons to contact in case of emergency:

_____ Relation: _____

Emergency contact information:

(home) _____

(work) _____

(cell) _____

Please answer yes/no to the following questions concerning your medical history

1. GENERAL MEDICAL HISTORY

_____ Asthma or other history of breathing difficulty/distress?

_____ Serious (requiring recurrent physician or hospital visits) gastrointestinal disturbances?

_____ Any disease or illness that has significantly limited activity or lifestyle?

_____ Diabetes?

_____ Bleeding/blood disorders?

_____ Hyper/hypotension?

_____ Seizures of any kind?

_____ Frequent dizziness or fainting?

_____ Cardiac problems?

_____ Surgeries?

2. MUSCLE/SKELETAL INJURIES

_____Knee, hip, shoulder, arm or ankle injuries?

_____Concussions?

_____Any joint or muscle/bone problems?

_____Head or back injuries?

3. ALLERGIES/MEDICATIONS

_____Any allergies of any kind (including medications)?

_____Have you ever been stung by a bee?

_____Have you been stung by a bee a second time? If yes, what was your reaction?

_____Any dietary restrictions or vegetarian/vegan?

_____Any medications currently taken? (Prescription, non-prescription, and nutritional supplements)

Name of medication _____

Dosage (amount/freq.) _____

Side effects/problems/Why taken? _____

4. PERSONAL HISTORY

_____Any treatment or referral to a mental health professional?

_____Currently in therapy/counseling?

_____ Is there anything else we should know about your health, both physical and mental, as the people you have legally entrusted with your care?

5. Provide details of condition - if answered "YES" above:

6. FITNESS/EXERCISE

Regular exercise - what?

Would you describe yourself as: VERY FIT FAIRLY FIT SOMEWHAT FIT UNFIT
Swimming ability: EXCELLENT GOOD FAIR SURVIVAL NON-SWIMMER

SIGNED THIS _____ day of _____, 20_____

Signature of Participant

Signature of Witness

Printed Name of Witness

Address & Phone Number of Witness