

**Pirate Queen Paddling  
Participant Health Form**

NAME \_\_\_\_\_ SS# \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PROGRAM \_\_\_\_\_ DATE \_\_\_\_\_

Please complete the following as thoroughly as possible. The information will be used only by the program manager and any emergency medical personnel. All material is confidential.

HEALTH INSURANCE CO. & POLICY NUMBER \_\_\_\_\_

1. What physical disabilities or conditions (heart conditions, diabetes, seizures, etc) do you have that might affect your participation in this activity including operations, illness, broken bones in the last six months?  
\_\_\_\_\_  
\_\_\_\_\_

2. Any allergies, specifically bee stings, food, or medications/drugs?  
\_\_\_\_\_  
\_\_\_\_\_

3. Last date of immunization (tetanus, booster, etc)? \_\_\_\_\_

4. List any medications being taken? \_\_\_\_\_

5. Name and phone number of family physician. \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

In the event that I am rendered unable to communicate due to illness, accident, or emergency while participating in this Program, I hereby give permission to the Physician, selected by Pirate Queen Paddling personnel, to hospitalize, secure proper treatment for, and to take whatever medical actions necessary to treat me.

\_\_\_\_\_  
Participant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Full Name (Printed)

\_\_\_\_\_  
Parent/Guardian Signature if under 18 years of age

\_\_\_\_\_  
Date