HEALTH QUESTIONNAIRE

Date: ______________________________

Full Name: ______________________________ DOB: ______________

Address: ______________________________

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Email: ______________________________

Phone: ______________________ Alt Phone: ______________________

Primary Care Physician: ______________________ Physician Phone: ______________

Medical Insurer: ______________________ Group | Policy No: ______________

Emergency Contact: ______________________ Relationship: ______________
Phone: ______________________ Alt Phone: ______________

Does your Doctor know you are going to participate in this program? Yes No

Does your emergency contact know you are going to participate? Yes No

Do you wear a Medic-Alert Tag or any other marker of a medical problem? Yes No
If Yes, please describe:

Do you have allergenic or anaphylactic reactions to any insults, such as environmental substances, foods, drugs, insect bites or stings? Yes No
If yes, please describe, and let us know if you carry an EpiPen or other fast-acting medication:

If you walked on the level for a mile at an average pace would you get out of breath, have pains in the chest, develop muscle fatigue or have pains in the legs? Yes No
Describe your fitness in your own words:

Do you have any other health-related disease, condition or concern that program guides should be aware of? Yes No
If yes, please describe:

This information is accurate and complete. I agree to communicate fully with program instructors and Guides any health concerns that may arise. I give my permission to staff of the Association of Nature and Forest Therapy Guides to seek emergency medical diagnosis or treatment for me in the event that I am unconscious or unable to make my own decisions. I understand that should I need medical care for any reason while participating in this program the role of Guides will be limited to emergency first-aid and either transportation to the nearest medical facility, or contacting such a facility to arrange emergency transport.

Signature: ______________________________