**Applicant Health/Medical Form** 

***On Sacred Ground (OSG) & Mid Sound Fisheries Enhancement Group (MSFEG)***

*In order to provide a safer and more successful experience for its participants, OSG and MSFEG requires completion of this Health and Medical Information Form as a requirement of participation. Please be honest and thorough; it is in your best interest to fully disclose medical information upfront so that OSG and MSFEG can be prepared to provide appropriate care and avoid potentially harmful situations. Applicant medical information is confidentially stored and will be shared with appropriate program staff only.*

**Applicant name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_\_\_

**Male/Female/Gender Identity\_\_\_\_\_**

**Who is completing this form**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Phone**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

1. Date of last Tetanus shot (month / year): \_\_\_/\_\_\_\_

*If the applicant has not had a Tetanus shot in the last 10 years we highly recommend getting one prior to program*

2. Check Yes or No to indicate any current or past conditions the applicant has experienced **in the last 2 years**:

• Chronic or reoccurring illness/condition ………... **Yes No**

• Hearing loss …………………………………….. **Yes No**

• Drug/alcohol addiction…………………………. **Yes No**

• Infectious condition …………………………….. **Yes No**

• Frequent headaches……………………………... **Yes No**

• Tobacco use ………………………………… **Yes No**

• Hospitalized or surgery………………………….. **Yes No**

• Vision/ wear glasses or contacts………………… **Yes No**

• High/low blood pressure……………………… **Yes No**

• Back pain/ injury ……………………………… **Yes No**

• Eating disorder ………………………………… **Yes No**

• Head injury ………………………………… **Yes No**

• Joint problems or injuries ……………………… **Yes No**

• Depression …………………………………….. **Yes No**

• Diabetes………………………………………… **Yes No**

• Broken bones …………………………………… **Yes No**

• ADD/ADHD …………………………………... **Yes No**

• Asthma …………………………………………. **Yes No**

• Dizziness or fainting …………………………… **Yes No**

• Bipolar Disorder ……………………………… **Yes No**

• Mononucleosis or Anemia……………………… **Yes No**

• Seizures …………………………………………. **Yes No**

• Oppositional Defiance Disorder………………… **Yes No**

• Heart condition…………………………………. **Yes No**

• Other relevant conditions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please explain any “YES” answers**. Note the question number and include specific dates, extent, and status of condition. If applicable, please describe activities or environments that may trigger or worsen the condition and steps that are being taken to manage the condition. Please be thorough.:

**ALLERGIES**

Please list all allergies to **Medications, Foods,** or **Environment** (insect stings, hay fever, animal dander, etc.).

1) Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Allergy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Last Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rx to Epinephrine? Yes/No Other Reactions? (Attach additional pages if necessary)

**MEDICATIONS**

**Circle one: No**, the applicant does not take any medications on a routine basis.

**Yes**, the applicant takes medication(s) as follows (attach additional pages if necessary). Please list ALL medications being taken, including over-the-counter or nonprescription drugs, by the applicant:

1) Medication (full name): Reason for taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date began and (if applicable) changed dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific times each day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special handling instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Medication (full name): Reason for taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date began and (if applicable) changed dosage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dosage: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific times each day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Side effects: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special handling instructions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other medications? Attach additional pages if necessary.

If the medication or dosage for any prescription drug has changed within the last three months, what was the change? Why and when did it occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**CURRENT HEALTH**

Please provide any additional information about the applicant’s physical, emotional, or mental health that OSG and MSFEG should be aware of. Please also use this space to list any accommodations the applicant may need in order to participate in the Mentors to Mentors Program (attach additional sheets if necessary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HEALTH/MEDICAL AGREEMENT AND RELEASE**

The information provided in this document is correct and complete to the best of my knowledge. I hereby give permission to OSG and MSFEG staff and leaders to seek emergency medical treatment and arrange necessary transportation in the event of an emergency and on my behalf.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ \_ Date :\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_