



AN ECOQUEST ADVENTURE

MEDICAL FILE

Name of Participant: _____ Age: _____

Address: _____

In case of emergency please contact:

Name: _____ Telephone: _____

Do you have any medical conditions we should know about? Yes No

If yes, please explain: _____

Are you taking any medications? Yes No

If yes, please indicate name(s) of the medication(s): _____

Are you allergic to any medication? Yes No

If yes, please specify medication(s): _____

Are you allergic to bee stings? Yes No

Are you allergic to any plants? Yes No

Do you have food allergies? Yes No

If yes, please specify: _____

If necessary, will you accept medical treatment? Yes No

Participant's Signature: _____ Date: _____