FOUR WINDS, INC.
MEDICAL INFORMATION and REGISTRATION FORM

Thank you for choosing Four Winds, Inc. Please, provide the following medical information so that we may properly care for you. This form is designed to inform the facilitator of any health condition or medication you may be taking. A complete disclosure, even seemingly unimportant information, will allow the facilitator to make better choices for your safety in certain situations or if a problem does occur. If you have questions or concerns, confer with your group's contact person or call us.

During the program, you will have opportunities to bend, stretch, run and climb, which may double your normal resting heart rate. You will be expected to make all decisions about whether any particular activity is appropriate for your health and fitness levels. If you doubt your ability to attempt the program activities described above and in the accompanying literature, consult a qualified health professional.

ORGANIZATION: ________________________________ PROGRAM DATE (S): _________________________

SECTION I: REGISTRATION

Name: ____________________________________ **Emergency Contact: Name:**_______________________

Address: __________________________________ **Relationship:**___________________________________

City, State, and Zip: ______________________________ **Phone:** (Day)________________ (Eve)______________

Phone:(home)_________________Sex: __________ Age: ___________ Height: _________ Weight: _________

Phone:(work)_____________ Occupation: ________________________ Employer: _______________________

SECTION II: MEDICAL INFORMATION

For each of the following, circle YES and EXPLAIN BELOW if you have any previous injuries, pre-existing conditions, special conditions or pertinent medical information. Otherwise, circle NO. This information will remain confidential.

	Yes	**No**		**Yes**	**No**		**Yes**	**No**
Eyes	Y	N	Lungs	Y	N	Restrictions to		
Ears/Hearing	Y	N	Asthma	Y	N	Strenuous Activity	Y	N
Neck/Shoulders	Y	N	High Blood Pressure	Y	N	Recent Surgery	Y	N
Recent Broken Bone	Y	N	Angina/Chest Pain	Y	N	Recent Major surgery	Y	N
Joint Dislocation	Y	N	History of Heart Disease	Y	N	Illness	Y	N
Diabetes	Y	N	History of Heart Attack	Y	N	Pregnant	Y	N
Epilepsy/Seizures	Y	N	Recurrent Back Problem	Y	N	Smoke Cigarettes	Y	N
History of Dizziness or			Groin/Hernia	Y	N	How many cigarettes per day? ____		
Fainting	Y	N	Contact Lenses	Y	N	Other	Y	N

EXPLAIN ANY 'YES' ANSWERS HERE:

*Please complete the *top, bottom and front* of this form to expedite medical care in the unlikely event of an emergency.

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Name: ____

Medical Insurance Carrier: ______________________________ **Policy #:** ___________________________

Your Doctor's Name: ___________________________ Phone: _______________________________________

Allergies (food, medicine, plants, etc.): ________________________Describe reaction: ____________________

Currently taking medication? Yes_____ No_____ Name of Medication: __________________________________

Dosage:_______________________Reason for medication: _______________________________________