

NERO® Massachusetts Medical History Emergency Information - 2010

Today's Date _____

NERO Massachusetts activities, like any active sport, involve a certain risk of injury. In the unlikely event that a participant is injured, NERO Massachusetts would like to take the appropriate actions. Please fill out this form completely and legibly. The information on this form is required for admission into any US hospital. The information will be held in strict confidence.

Participant Name (please print): _____

Address: _____ Phone: _____

City/St/Zip _____ DOB: _____

Parent or Legal Guardian (if under 18) (please print): _____

Parent/Guardian Phone: (____) _____

Does the participant have any CURRENT medical conditions that NERO Massachusetts needs to know about to ensure the participant's safety in the event medical treatment is needed? If yes, please list. Include allergies (including bee stings), adverse reactions to any medical drugs, asthma, diabetes, fainting spells, heart trouble, convulsions, bleeding disorders, or any other problems. (If you have life-vital medicine you may need during an event, it is recommended that you leave a dose with the EMT staff.)

No _____ Yes _____(please explain)

Please list any medicines taken on a daily basis while at NERO:

Please list any major PAST medical events (surgeries, hospitalizations, etc.):

This health history is correct as far as I know, and the person herein has permission to engage in all prescribed activities. In the event I, or the person listed below, cannot be reached in an emergency, I hereby give permission to have 1) NERO Massachusetts EMTs and/or staff members render first aid, and 2) any physician hospitalize, secure proper anesthesia, or order injection for (participant's name):

_____ (print name)

Signature of Participant (if 18 or older) or Signature of Parent/Legal Guardian (if participant is under 18):

In Case of Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone: (____) _____

Medical Insurance Information for Participant (Plan or Policy Number): _____

Family Doctor: _____ Phone: (____) _____