

# Earth Explore Leader Health Form

Leader Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Primary Health Insurance Provider \_\_\_\_\_

Group Number \_\_\_\_\_ Subscriber Name \_\_\_\_\_

*To Be Filled Out By Leader:*

1. Have you suffered from any serious illness within the last two years? Please specify. \_\_\_\_\_  
\_\_\_\_\_

2. Do you have any disease, impairment or abnormality of the body? \_\_\_\_\_  
\_\_\_\_\_

3. Have you been treated for any psychological condition within the last two years? If so, please describe. \_\_\_\_\_  
\_\_\_\_\_

*If the answer to any of the above is yes, a physician's letter of authorization to travel is required.*

4. Have you had surgery or been hospitalized within the last two years? If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

5. List any medications you are currently taking. \_\_\_\_\_  
\_\_\_\_\_

*To Be Filled Out By Physician or Authorized Physician's Assistant:*

1. Is there any evidence of the following? If yes, please circle and attach details.

Diabetes	Hernia	Rheumatic fever	Any present communicable disease
Mental disorder	Malaria	Epilepsy	Tuberculosis

2. Any disease, impairment or abnormality of the following? If yes, please circle and attach details.

Eyes or sight	Ears or Hearing	Genitourinary system	Lungs, respiratory system
Tonsils, nose or throat	Heart or blood vessels	Bones, joints, locomotor	Brain or nervous system
Stomach or digestive system	Skin	Other abdominal organs	Blood or endocrine system

3. Describe in detail any medication or treatment received during the past year. \_\_\_\_\_  
\_\_\_\_\_

4. Describe any allergies to food or medicines. \_\_\_\_\_  
\_\_\_\_\_

5. In my opinion the Leader's health is:    Excellent    Good    Fair    Poor

Physician/Assistant Signature \_\_\_\_\_ Phone \_\_\_\_\_

Physician/Assistant Name \_\_\_\_\_ Date \_\_\_\_\_

*I hereby authorize and give full consent to the other Leader(s)/Earth Explore to act on my behalf to ensure prompt medical care and attention in case of illness or accident incurred by myself while participating in the Earth Explore Adventure Program. I authorize the other Leader(s)/ Earth Explore to incur necessary expenses, and I agree to pay the same in excess of amounts covered by applicable insurance.*

Leader Signature \_\_\_\_\_ Date \_\_\_\_\_