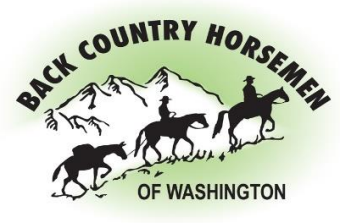

Volunteer: _____ Date: _____

Emergency Contacts:

Primary Contact: _____
Relationship: _____
Home number: _____
Cell: _____

Secondary Contact: _____
Relationship: _____
Home: _____
Cell: _____

Are you allergic to bee stings? If so, how severe is your reaction? _____

Do you carry an anaphylaxis kit? Yes or No?

Do you have any other allergies? Please describe, noting the type and severity.

_____

Please describe any injuries, operations, or hospitalizations you've experienced in the last year.

_____

Describe any illnesses or pre-existing conditions. For example, hepatitis, Lyme disease, heart or lung conditions. _____

Do you have any heat illness concerns or circulation issues due to cold weather?

_____

Are you taking any medications? List type, dosage, frequency of use, side effects and purpose.

_____

Please state below any other health conditions, limitations, or restrictions of which you are aware.

_____