Green University, LLC

PO Box 697 – Pony, MT 59747 – 406-685-3222

Participant Medical History & Consent for Medical Treatment

Name: _____ Sex: M / F Date of Birth: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work: _____

Please provide at least two people to contact in case of an emergency:

Name: _____ Relationship: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work: _____

Name: _____ Relationship: _____
Address: _____
City, State, Zip: _____
Home Phone: _____ Cell Phone: _____ Work: _____

Personal Physician: _____ Office Phone: _____
Address: _____ City: _____ State: ___ Zip: _____

List of known Allergies: _____ List of current Medications: _____
_____ _____
_____ _____

Does you have any medical implants? _____ Wear contacts? _____ Pregnant? _____

Circle and explain your medical history (including but not limited to):

asthma	angina	altitude problems	allergic reactions
back problems	blackouts	chest pains	concussions
diabetes	drug reactions	dislocations	epilepsy
heart conditions	mental disabilities	seizures	surgeries
unusual blood pressure			

Please explain in detail and note any other conditions that might limit your participation:

I agree to allow Green University, LLC to arrange any necessary emergency medical care needed in the event that I am incapacitated. I further agree to pay all charges for this necessary emergency care.

_____ _____ _____
Printed name Signature Date