

Hey Crew,

I need your help with the major emergency and trauma first aid kit... First If you could take some time and complete the following medical information form and return this form to me as soon as possible.... I will print these forms and they will accompany us on the trip and in the case of evacuation or medical air lift these forms will accompany you to the ER. Providing valuable information to flight nurses, ER Doc's and your Insurance company (not necessarily in that order). This form will also be helpful in the event of any kind of emergency first aid that we may need to perform ourselves... so please complete it and get it back to me via email. These forms will be keep with the emergency first aid kit - also in accordance with HIPAA privacy regulations these forms will be burned in the camp fire on our last night -

Second the expense of some the prescription drugs that I will be getting are expensive and I could use your help by reducing the cost of the over-the-counter stuff that I would normally purchase to stock a major first aid kit. I need each of the participants to purchase and bring their own personal OTC Meds:

1 bottle of Pain revilers (Advil, Tylenol, 222's whatever you normally use),
1 box of Pepto-Bismol (tabs) or whatever you prefer to take for upset stomachs and rot-gut,
1 box of Imodium tabs (anti-diarrhea) in case of amebic-dysentery, Cryptosporidium and/or Giardi, or the old Tijuana 2-step...
1 large pad of mole-skin (foot blisters),
A medium tube or can of tiger balm, Ben gay, deep-heat (for your sore muscles),
Any personal Prescription medications that you will need...

If everyone brings their own over-the-counter stuff it will help greatly and we will not have to bear the expense of stocking enough of these items for all 16 people.

Thank you for your help and assistance in completing the medical information from and purchasing your over-the-counter Rx.

Looking forward to meeting you all @ Lee's Ferry...
With Regards & Respect

Michael Christner
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PART I - GENERAL INFORMATION

NAME _____

ADDRESS _____

CITY/STATE/ZIP _____

HOME PHONE () _____

BIRTH DATE _____ AGE _____ MALE _____ FEMALE _____

EMERGENCY CONTACT _____ RELATIONSHIP _____

DAY PHONE () _____ EVENING PHONE () _____

PHYSICIAN _____

PHYSICIAN ADDRESS _____

CITY/STATE/ZIP _____

PHYSICIAN PHONE () _____

1. Are you covered by any hospitalization and medical care policy? Yes _____ No _____
2. Insurance Company: _____
3. Policy/Group Number: _____
4. Insurance Company Address _____
5. Does the insurance company require pre-authorization? Yes _____ No _____
 - a. If yes, please give phone number () _____

PART II - MEDICAL HISTORY: Past and Present Medical Issues

A. Conditions and symptoms. Have you had, or do you currently have, any of the following conditions or symptoms?

	YES	NO		YES	NO
1. High Blood Pressure			2. Motion Sickness		
3. Heart Disease			4. Sleep Walking		
5. Heart Murmur			6. Broken Bones		
7. Irregular Heartbeat			8. Neck Problem		
9. Tuberculosis			10. Back Problem		
11. Recent exposure to active TB			12. Arm Problem		
13. History of TB			14. Shoulder Problem		
15. Positive TB test			16. Knee Problem		
17. Active Hepatitis			18. Ankle Problem		
19. History of Hepatitis			20. Leg Problem		
21. Seizure Disorder			22. Foot Problem		
23. Seizure within the past year			24. Currently Pregnant		
25. Bleeding Disorder			26. Special Diet		
27. Asthma			28. Learning Disability		
29. Diabetes			30. Blood Condition (anemia, sickle cell trait)		
31. Hypoglycemia			32. Use of Medical Equipment Devices		
33. Anorexia Nervosa			34. Communicable Disease		
35. Bulimia			36. What When		
37. Cancer			38. Other		
39. Skin Problem			Do you currently or regularly have any of the following symptoms?		
40. Frostbite					
41. Circulation Problems			42. Chest Pain/Pressure		
43. Active Bedwetting			44. Heart Palpitations		
45. Headaches			46. Unexplained Sweating		
47. Stomach Ulcers			48. Frequent Shortness of Breath		
49. Intestinal Problems			50. Frequent Dizziness		
51. Jaundice Problems			52. Frequent Fainting		
53. Heatstroke			54. Heartburn		
55. Bladder Infection			56. Muscle Cramps		
57. Difficulty Urinating			58. Intolerance of warm temperatures		
59. Endocrine Problems			60. PMS or menstrual problems		
61. Hearing Impairment			62. Other		
63. Vision Impairment					

If you answered “YES” to any of the above items, please explain below. Including the following:

- What specific symptoms are occurring
- How often symptom/conditions occurs
- How long symptom/condition lasts
- How you care for symptom/condition
- Date of last occurrence
- How symptom/condition restricts your activity in any way, including your ability to run, lift, and climb.

Item #	Detailed Description (including restrictions, if any)

Allergies

Allergy	Reaction	Medication Required

B. Medications

Medication	Condition	Dosage (size & frequency)	Possible Side Effects

C. Immunizations

Immunization	Requirement	Date of Last Immunization
Tetanus	Within last 8 years	

D. Hospitalization/Emergencies

Please list any hospital or emergency department visits.

Dates	Reason	Length of Stay

E. Personal History

Height _____ Weight _____ Blood Pressure _____ Resting Pulse _____

F. Anything else that a flight nurse might need to know as they airlift your dying ass out of the canyon?