

Edgewood Consulting & Services

PO Box 122, New Paltz, NY 12561

(845) 255-7007

Program Date: _____

Program Type: _____

People in Group: _____

Location: _____

MP Member: Yes or No

Other _____

**Please call if you have any questions about this form.*

STAFF COMPLETE LIST ABOVE

It is necessary that you disclose your current health and relevant health history. This information is necessary so in the unlikely event of an accident the staff person can assist you. Please read this form carefully and fill it out accurately and completely. Everything is important. Completed medical forms must be received at least 10 days in advance. Thank you for your cooperation.

Medical History Questionnaire & Release for ADULTS (ages 18 and up)

(Confidential)

General Information:

Full Name: _____ Date: _____
(First Name , Last Name)

Gender (circle one): Male or Female DOB: _____ Age: _____

Height: _____ Weight: _____ Email: _____

Home Address: _____

Home Phone #: _____ Cell Phone #: _____

Are you a member of the Mohonk Preserve? (circle one) Yes No

Emergency Contact Information:

Emergency Contact Person's Name: _____

Emergency Contact Person's Relationship to you: _____

Phone Numbers for Emergency Contact: Home _____

Work _____ Cell _____

Home Address for Emergency Contact Person: _____

Medical Insurance Information:

Do you have medical health insurance? Yes or No

If yes, with what company? Company's Name: _____

Policy Holder's Name: _____ Policy #: _____

Primary Physician's Name: _____ Phone #s: _____

If you do not have insurance, please initial below that you acknowledge the risk of & will assume full responsibility for incurred medical expenses in the event that something happens to you while participating in an Edgewood Consulting & Services Program that requires medical care.
Initial Here _____

