Health History

OUTDOOR ADVENTURE PROGRAM

Name:_____ Outing Name:_____
Date:_____

We require full disclosure of you current health. The information you provide may assist people in the event of an accident. Therefore, please read it carefully; full and accurate completion of all sections is very important. This information otherwise shall be kept confidentially between the trip leader(s), the Coordinator and health care professionals in the event of an accident.
We do not use this information in evaluating your ability to participate in any activities. Only qualified health professionals can make that decision. If you are at all concerned about your ability to participate in any aspect of the activity, please seek the advice of a health care professional. By completing this form you are acknowledging your awareness of the above information.

Gender: Male or Female Age:_____ Blood type:_____ Height:___'____" Weight:_____(lbs.)
Home Adress:_____
Home Phone: _____ Work Phone: _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:_____ Relationship:_____
Address:_____
Home Phone:_____ Work Phone:_____
Doctor's Name:_____ Doctor's Phone:_____
Doctor's Address:_____
Medical Policy:_____ Policy Number:_____

PLEASE LIST ALL INFORMATION REGARDING THE FOLLOWING:

Are you under treatment for any illness or condition? _____ If so, please name and describe: _____
_____

Are you currently taking any medication(s)? _____ If so, please name and describe:_____
_____

Do you have any allergies? _____ Are you allergic to bee stings or insect bites? _____ If so, please explain: _____
_____

Do you have any past injuries? _____ Have you had a cold injury? _____ Have you had a heat injury (i.e. exhaustion) ?_____
If so please name and describe:_____

Do you have a history of heart problems? _____ If so, please explain: _____

Have you ever undergone surgery? _____ If so, please describe procedures: _____
_____Was anaesthetic local or general?_____

Dietary restrictions (vegetarian, lactose intolerance etc.) _____

Are you First Aid and/ or CPR certified?: _____ Expiration Date: _____ Can you swim? _____
Do you smoke? _____ Do you wear glasses/contacts? _____ Do you have dentures/false teeth? _____

PLEASE WRITE BELOW ANYTHING YOU FEEL WE SHOULD BE AWARE OF CONCERNING YOUR HEALTH. THANK YOU.

_____
_____
_____
_____