SIERRA CLUB OUTINGS

Medical Form

Please complete this form and return it to your leader within 30 days.

We ask for this information so that the trip leaders will know in advance of special medical conditions you may have, rather than learning about them in a crisis. Also, in the event of serious injury or illness, this form provides emergency medical personnel with a useful medical history. After reviewing this form, the leader may contact you to discuss whether the trip will be safe and enjoyable for you considering your medical history.

We will keep the information on this form confidential. It will be seen only by the trip leaders, medical personnel, or others who know and understand its confidential nature. The form will be retained along with your liability waiver for a period of time following the trip, after which it will be destroyed. If you choose not to go on the trip, this form will be destroyed immediately.

General Information

Name: _____ **Gender:** ☐ Male ☐ Female

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home: (____) _____ **Work:** (____) _____ **Cell:** (____) _____

E-mail address: _____ **Date of Birth:** _____

Height: _____ **Weight:** _____ **Blood Pressure:** _____ **Resting Pulse:** _____

Primary Emergency Contact: _____ Relationship: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

Secondary Emergency Contact: _____ Relationship: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

Evacuation and Medical Insurance

We strongly encourage you to have medical and evacuation insurance and to bring your insurance card or other documentation with you on the trip.

Evacuation Insurance ☐ **NONE**	**Medical Insurance** ☐ **NONE**
Company Name:	Company Name:
Policy Number:	Policy Number:
Contact Phone Number:	Contact Phone Number:
Coverage Amount:	

Allergies ☐ NONE

Include allergies to medicines, foods, insect bites and stings, animals and environment (dust, pollen, etc.).

Allergy	Reaction	Medication Required (if any)

OVER →

Medications ☐ NONE

Please list all prescription, over-the-counter, and natural medications you are taking. ***Use a separate sheet if necessary.***

Medication Name	Dosage	Frequency	Side Effects (known & potential)	Reason for Taking

Medical History

Please answer the following medical history questions. ***Use a separate sheet to explain history in more detail.***

- Recent illness within the last 12 to 18? ☐ Yes ☐ No ***If yes, please explain.***
- Have you had surgery or been hospitalized in the last year? ☐ Yes ☐ No ***If yes, please explain.***
- Recent exposure to infectious diseases within 12 to 18 months? ☐ Yes ☐ No ***If yes, please explain.***
- Do you have asthma? ☐ Yes ☐ No ***If yes, please list any medications above and explain on separate sheet.***
- Do you have diabetes? ☐ Yes ☐ No ***If yes, please list any medications above and explain on separate sheet.***
- Do you have a history of high blood pressure? ☐ Yes ☐ No
- Do you have a history of heart disease? ☐ Yes ☐ No ***If yes, please explain.***
- Do you wear glasses? ☐ Yes ☐ No **(*If you wear prescription glasses or contacts, we recommend bringing a spare set.)***
- Any history of eye or vision problems (e.g. glaucoma, detached retina)? ☐ Yes ☐ No ***If yes, please explain.***
- Do you have any problems with your hearing? ☐ Yes ☐ No ***If yes, please explain.***
- If female, are you pregnant? ☐ Yes ☐ No
- Do you have any bone, joint, or muscle problems? ☐ Yes ☐ No ***If yes, please explain.***
- Have you ever had a seizure? ☐ Yes ☐ No ***If yes, please explain.***
- Have you ever experienced altitude problems? ☐ Yes ☐ No ***If yes, please explain.***
- Do you have any other medical issues that might affect your participation in this trip? ☐ Yes ☐ No

  If yes, please explain: _____
- The outing may require vigorous activity, extended climbing and hiking, and other physically and mentally demanding exertion in isolated areas without medical facilities, medical providers, or means of contacting rescue or medical personnel. Please state below all physical or mental limitations and restrictions of which you are aware:

  If you have no such limitations, please initial here: _____

  _____
- **Tetanus:** It is strongly advised that you are inoculated against this fatal disease and you obtain a booster within every 10 years. The date of your most recent tetanus inoculation or booster: _____/_____/_____

Physical Examination

Date of most recent physical: _____/_____/_____ Physician's name: _____

Address: _____ Phone Number: _____

Physician's signature (if required): _____

Please notify your trip leader immediately if any information on this form changes.

Trip Name: _____ **Trip Dates:** _____

Signature (required): _____ **Date:** _____/_____/_____