



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: <input type="checkbox"/> Male <input type="checkbox"/> 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.

| <u>Evacuation Insurance</u> <input type="checkbox"/> NONE | <u>Medical Insurance</u> <input type="checkbox"/> 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) |
|---------|----------|------------------------------|
| | | |
| | | |
| | | |

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 |
|-----------------|--------|-----------|----------------------------------|-------------------|
| | | | | |
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| | | | | |

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:** _____ / _____ / _____