

The University of Michigan Outdoor Adventures: Medical Information Form (2007-2008)



Please fill out every item below as accurately and truthfully as possible. Provide details for any significant conditions, injuries and/or illness that may affect your ability to participate with the Outdoor Adventures Program. This form is the property of the Outdoor Adventures Program and will remain as a confidential record to the fullest extent permitted by law. Only the instructors and medical personnel have access to this information.

Name: _____ Name of Program: _____

Home Address: _____ Date of Program: ____/____/____

Sex: Female or Male

Home Phone: (____) _____ Age: _____ Birthdate: ____/____/____

Height: _____ Weight: _____

In case of emergency, please contact:

Name: _____ Relationship: _____

Address: _____ Home Phone: (____) _____

Work Phone: (____) _____

Doctor's Name: _____ Doctor's Phone: (____) _____

Is the participant covered by medical insurance? YES or NO

Medical Insurance Company: _____

Policy Number: _____

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|---|--|
| 1. If over age 35, what is your current Blood Pressure: _____ | Date last checked: _____ |
| a. Do you have any known heart conditions and/or high blood pressure? | YES or NO ** |
| b. Are you taking any medication for this condition? | YES or NO If YES, what? _____ |
| 2. Are you Pregnant? | YES or NO If YES, how far along? _____ ** |

**** If you answered yes to questions 1 or 2, please consult your physician concerning your participation in the Outdoor Adventures Program. Please Note: Outdoor Adventures Program does not provide medical insurance for participants.**

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| 3. Are you currently under other Physician Orders for medication or treatment? | YES or NO |
| 4. Will you bring these medications with you when you participate in our program? | YES or NO |
| 5. Are you allergic to insect stings, poison ivy, foods, drugs or other things? | YES or NO |

6. Please circle any of the following conditions that pertain to you.

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|-----------------------------|-----------------------------|-------------------------|
| a. Diet or Eating Disorders | e. Past Injuries/Illnesses | i. Epilepsy/Convulsions |
| b. Respiratory Conditions | f. Neck/Spine/Back Problems | j. Past Operations |
| c. Asthma | g. Fractures | k. Other Medications |
| d. Physical Disabilities | h. Diabetes | l. Other |

If you answered YES to questions 3, 4, 5, or circled a condition from the above list, please: list the medications, dosage and the frequency with which these are taken; describe specific allergies, your symptoms, the frequency of occurrence, how you care for the condition and how this condition restricts your activity in any way; and/or describe all information, including specific symptoms, how long the symptom/condition lasts, frequency of occurrence, how you care for symptom/condition, and how the condition restricts your activity in any way. Use additional paper if necessary.

Authorization for Emergency Medical Care: Should an accident or emergency occur, I hereby give permission to the physician selected by The University of Michigan Outdoor Adventures Program Staff to hospitalize and/or secure proper medical treatment for me, except as noted below. I agree to hold only myself liable for these noted exceptions.

EXCEPTIONS FOR TREATMENT/HOSPITALIZATION:

Signature _____ Date _____

Name (Please Print) _____

Signature of Parent or Guardian (if under 18 years old) _____ Date _____