

The University of Michigan Outdoor Adventures: Medical Information Form



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: _____

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.**

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.**
- | | | |
|-----------------------------|-----------------------------|-------------------------|
| 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 _____