

**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: \_\_\_\_\_ Date of Program: \_\_\_\_\_

Home Address: \_\_\_\_\_ 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      If YES, what? _____          |
| 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.**

- |                             |                             |                         |
|-----------------------------|-----------------------------|-------------------------|
| 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 \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_

Name (Please Print) \_\_\_\_\_

Signature of Parent or Guardian (if under 18 years old) \_\_\_\_\_ Initials \_\_\_\_\_ Date \_\_\_\_\_