CALVIN OUTDOOR RECREATION MEDICAL FORM:

COURSE/CLASS/TRIP: _____

PERSONAL AND EMERGENCY CONTACT INFORMATION

NAME: _____EMAIL_____ PHONE: _____

GENDER: _____BIRTHDAY: _____AGE: _____HEIGHT _____WEIGHT_____ YEAR IN SCHOOL: _____

LOCAL ADDRESS: _____

HOME ADDRESS: _____

EMERGENCEY CONTACT INFO:

NAME/RELATION: _____ PHONE: _____EMAIL: _____

HOME PHYSICIAN: _____ PHONE: _____

INSURANCE INFORMATION: _____Policy #_____Group #_____

PERSONAL HEALTH INFORMATION:

LIST ALL NOTABLE <u>ALLERGIES (food, insects, meds, etc.);</u> please describe your last allergic reaction: how is a reaction best prevented? How is it best remedied?
LIST ALL SPECIAL <u>DIETARY NEEDS;</u> are you willing to bring you own food if necessary? Y/N_____
LIST ALL <u>MENTAL HEALTH CONCERNS;</u> are you currently seeing a therapist or mental health specialist? Y/N_____
LIST <u>PERTINANT MEDICAL HISTORY</u>; any current, recent, or historic injuries, illnesses, or medical procedures:
LIST ALL <u>CURRENT MEDICATIONS/PERSCRIPTIONS</u> that you are taking or have taken during the past 6 months: ***Meds: _____ Dose: Frequency: _____Side Effects: _____***
LIST ANY PAST OR CURRENT <u>HEALTH CONDITIONS</u> that might impact or effect your ability to perform all daily skills and complete daily mileages and moderate to high intensity physical activities

PERSONAL MEDICAL HISTORY CHECKLIST

Select Yes or No and describe any issue, illness, or injury, <u>current or past</u> that might affect your ability to participate fully and safely in this activity.

Y or N	1. Respiratory Issues	
Y or N	2. Gastrointestinal Issues	
Y or N	3. Diabetes	
Y or N	4. Hypertension Issues	
Y or N	5. Blood or Bleeding Disorders	
Y or N	6. Hepatitis or Liver Disorders	
Y or N	7. Neurological Problems; Epilepsy	
Y or N	8. Seizures	
Y or N	9. Dizziness/Fainting	
Y or N	10. Treatment or Meds for Menstrual Issues	
Y or N	11. Treatment or Meds for Reproductive Tract	
Y or N	12. Broken Bones	
Y or N	13. Muscle/Skeletal Injuries	
Y or N	14. Common Athletic Injuries	
Y or N	15. History of Altitude Sickness, Heat Illness, or Frostbite	
Y or N	16. Vision or Hearing (contacts)	
Y or N	17. Back or Neck Pain	
Y or N	18. Head Injury	
Y or N	19. Skin Issues	
Y or N	20. Heart Condition	
Y or N	21. Kidney Condition	
Y or N	22. High or Low Blood Pressure	
Y or N	23. Hernia	
Y or N	24. Other:	

FITNESS: Do you exercise 2-3 times per week: Y/N_____ Please list below:

ACTIVITY:	**FREQUENCY**	**DISTANCE/DURATION**	**INTENSITY**

Do you smoke? Y/N_____

In case of any accident, I give my permission for the leaders of this activity to seek emergency medical services for me or my child with the understanding that I am responsible for any expenses incurred (medical insurance is your responsibility).

Signature: _____ **Date:** _____

Print Name: _____

Parent Signature (if under 18)_____**Date:**_____