

Ohio University Outdoor Pursuits

Medical Form

This form will be used in the event of injury or illness to provide emergency medical personnel with useful medical information. This medical form will not be used as a screening tool. If you have any questions regarding your ability to participate in the activity due to medical reasons please contact a physician. Staff and medical personnel will keep the information on this form confidential. If you need special accommodations for any reason, including medical, please notify staff.

General Information

Name: _____ Gender: Male Female
Last First M.I.

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

E-mail: _____ Date of Birth: _____ Age: _____

Emergency Information

Primary Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Secondary Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Medical Insurance

Please provide current insurance information.

Insurance Company: _____ Contact Phone (if applicable): _____

Policy Number: _____ Group Number: _____

Policy Holder: _____ Holder Contact Number: _____

Allergies

Include medicines, foods, animals, insect bites and stings, and environment (dust, pollen, etc.) None

Allergy	Reaction	Medication Required (if any)

Dietary Restrictions: _____

Medical History

Please check any of the following conditions that apply to you and provide any details pertaining to this condition.

- Yes No *Operations/Serious Injuries in the past 5 years* _____
 - Yes No *Hospitalization/E.R. visits in past 12 months* _____
 - Yes No *Asthma/Respiratory Do you use an inhaler?* _____ *What triggers attacks?* _____
 - Yes No *Diabetes (Please note if insulin dependent.)* _____
 - Yes No *High Blood Pressure (Last known B.P.)* _____
 - Yes No *Major Joint/Tissue/Bone Injuries (i.e. neck, back, knee, shoulder, ankle, breaks, etc.)* _____
 - Yes No *Hearing Problems* _____
 - Yes No *Seizure/Epilepsy Date of last seizure:* _____ *What triggers seizure?* _____
 - Yes No *Heart/Cardiac Conditions or Surgery* _____
 - Yes No *Bleeding Disorder (i.e. Anemia)* _____
 - Yes No *Hepatitis or Other Liver Disease* _____
 - Yes No *Fainting/Blackouts/Dizziness What triggers this?* _____
 - Yes No *Eye/Vision* _____
- (Note: If you wear prescription glasses or contacts, we recommend bringing a spare set.)
- Yes No *Are you currently pregnant?* _____ *If yes, how far along?* _____
 - Yes No *Other Health or Medical Issues* _____

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

Outing participants must understand the use of any prescription medications they may be taking. All students who are required by their personal physician, psychiatrist or other health care provider to take prescription medications on a regular basis must be able to do so on their own and without additional supervision.

Acknowledgement

I understand the importance of providing accurate medical information and I certify to the accuracy of the foregoing information. I further contend that I am in good health and know of no personal physical or mental limitations that would prevent my participation on this trip (unless noted). In the event of illness or injury occurring to me or to my child (if participant is younger than 18) during attendance of the trip, I do hereby consent to any X-ray examination, anesthesia, medical or surgical diagnostic procedure performed by or suggested by the attending licensed physician, as well as treatment that is considered reasonable and necessary in the best judgment of and performed by or under the supervision of a member of the staff of Ohio University. I understand that in the event of a serious illness or injury, reasonable efforts to notify those listed in case of emergency will be attempted.

Participant Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If participant is under 18 years of age)