

ADVENTURE PURSUITS MEDICAL FORM



This trip involves participation in outdoor activities which are, by nature, physically demanding. Therefore, all participants must be free of medical or physical conditions which might create undue risk to themselves or to others who depend on them. In addition to being more exposed than usual to weather changes, you may travel long distances over mountainous terrain. Furthermore, professional medical attention may be several hours away in the case of an emergency. Though great physical strength is not necessary for participation in this activity, good physical condition will enhance the experience. If there is any doubt whatsoever about your ability to safely participate in this activity, you should have a physical examination by a physician. We may also require a physician's consent as a precondition for participation depending upon the information you provide. Rest assured that we will hold this information in the strictest confidence.

A. GENERAL INFORMATION (Please Print)		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Name	Towson ID #	Today's Date	
Address	Birth Date	Home Phone	
	Present Age	Business Phone	
Family Physician		Phone	
Address			
Person to be notified in case of illness or injury		Home Phone	
Address		Business Phone	
		Relationship	
B. INSURANCE INFORMATION <i>Each participant must have health insurance.</i>			
Is the participant covered by a hospitalization and medical care policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Company	Certificate #
C. MEDICAL HISTORY <i>All items must be completed.</i>			
<i>Do you now have or have you ever had...</i>			
1. high blood pressure, heart trouble, or circulatory conditions/problems?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. rheumatic fever, anemia, or diabetes?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. a hernia, hemorrhoids, or rectal ailments?		<input type="checkbox"/> Yes	<input type="checkbox"/> No

4. prostrate, kidney, or bladder trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. ulcers, colitis, stomach trouble, or chronic constipation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. irregular or excessive menstrual bleeding or toxic shock syndrome?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. cancer, tumors, or cysts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. a nervous, emotional, or mental disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. seizures, epilepsy, or fainting spells?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. eye or ear problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. asthma or other respiratory problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. allergies to drugs, foods, bee stings, poison ivy, iodine, etc.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. arthritis or rheumatism?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
14. back trouble?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
15. fractures, dislocations, strains, or sprains?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
16. mononucleosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
17. Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
18. Any condition not listed for which you have been treated?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If you answered yes to any of the above, please describe your condition(s) on a separate page. Be sure to indicate the year of initial occurrence, whether you are currently under treatment, and any medications you are currently taking.

Medication

Dosage

Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____

If you answered yes to number 12 and have had severe reactions to bee stings, we recommend that you carry the appropriate medication (e.g., Ana-kit or Epi-pen), that you know how to use it, and that you inform us where you will keep it. If in doubt, consult your physician. **Be sure to identify any other allergies on a separate page as directed above. We do not carry Epinephrine in our medical kits.**

D. SIGNATURE

I fully understand the rigorous nature of this outdoor program. In the event of an emergency, I give my permission for any medical treatment, including, but not limited to, surgery and/or anesthesia which might become necessary.

Participant's Signature: _____ **Date:** _____

Signature of parent or guardian (if participant is under 18 years old):

_____ **Date:** _____