ADVENTURE PURSUITS

MEDICAL FORM

This trip involves participation in outdoor activities which are, by nature, physically demanding participants must be free of medical or physical conditions which might create undo risk to themse who depend on them. In addition to being more exposed than usual to weather changes, you may trav 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)

☐ Male ☐ 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

Each participant must have health insurance.

Is the participant covered by a hospitalization and medical care policy?	☐ Yes ☐ No	Company	Certificate #

C. MEDICAL HISTORY

All items must be completed.

Do you now have or have you ever had...

1. high blood pressure, heart trouble, or circulatory conditions/problems?	☐ Yes	☐ No
2. rheumatic fever, anemia, or diabetes?	☐ Yes	☐ No

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

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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.**

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:_______________