WFU Outdoor Pursuits – Medical Form

Name _____

Address _____

Email Address _____

City/State/Zip _____ Birth Date _____/_____/_____

Day Phone (_____) _____ Evening Phone (____) _____

Gender: Male _____ / Female _____ WakeID# _____

Father/Guardian _____ **Mother/Guardian** _____

City/State/Zip _____ City/State/Zip _____

Occupation/Title _____ Occupation/Title _____

Day Phone (_____) _____ Day Phone (_____) _____

Evening Phone (____) _____ Evening Phone (____) _____

Cell Phone (____) _____ Cell Phone (____) _____

Email Address _____ Email Address _____

Emergency Contact
(other than parents) _____

Relationship _____

Day Phone (_____) _____

Evening Phone (____) _____

Cell Phone (____) _____

Insurance Information
Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance.

Insurance Company Name _____ Policy Number _____

Claim Billing Address _____ City/State/Zip _____

Prescription Plan Name _____ Policy Number _____

Claim Billing Address _____ City/State/Zip _____

NOTE: ATTACH A PHOTOCOPY OF BOTH THE FRONT AND BACK OF YOUR INSURANCE CARD(S) TO THIS FORM.

SIGNATURES REQUIRED

Consent is hereby given for the applicant to attend a WFU OUTDOOR PURSUITS program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary.
All information will remain confidential.
Failure to disclose such information could result in serious harm to you and your fellow students.

Student's Signature **Date**

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PAST AND PRESENT MEDICAL PROBLEMS

CONDITIONS AND SYMPTOMS

	Yes	No		Yes	No		Yes	No
1.High Blood Pressure	□	□	24.Frostbite	□	□	47.Ankle Problem	□	□
2.Heart Disease	□	□	25.Circulation Problems	□	□	48.Leg Problem	□	□
3.Heart Murmur	□	□	26.Active Bed-wetting	□	□	49.Foot Problem	□	□
4.Irregular Heartbeat	□	□	27.Headaches	□	□	50.Currently Pregnant	□	□
5.Family history of heart attack	□	□	28.Head injury w/	□	□	51.Special Diet	□	□
6.Tuberculosis	□	□	neurological impairments			52.Learning Disability	□	□
7.Recent exposure to active TB	□	□	29.Stomach Ulcers	□	□	53.Medical Equipment	□	□
8.Positive TB test	□	□	30.Intestianl Problems	□	□	54.Unexplained weight loss	□	□
9.Active Hepatitis	□	□	31.Heatstroke	□	□	55.Other	□	□
10.History of Hepatitis	□	□	32.Bladder Infection	□	□			
11.Seizure Disorder	□	□	33.Difficulty Urination	□	□	Do you currently or regularly have		
12.Seizure within past year	□	□	34.Kidney Problems	□	□	any of the following symptoms?		
13.Bleeding Disorder	□	□	35.Thyroid Problems	□	□	56.Chest Pain/Pressure	□	□
14.Blood disorder/anemia/	□	□	36.Endocrine Problems	□	□	57.Heart Palpitations	□	□
Sickle cell trait			37.Hearing Impairment	□	□	58.Shortness of Breath	□	□
15.Chronic cough	□	□	38.Vision Impairment	□	□	59.Unexplained Sweating	□	□
16.Recurrent lung infections	□	□	39.Motion Sickness	□	□	60.Frequent Dizziness	□	□
17.Asthma	□	□	40.Sleep Walking	□	□	61.Frequent Fainting	□	□
18.Diabetes	□	□	41.Broken Bones	□	□	62.Heartburn	□	□
19.Hypoglycemia	□	□	42.Neck Problem	□	□	63.Muscle Cramps	□	□
20.Anorexia Nervosa	□	□	43.Back Problem	□	□	64.Intolerance to warm temps	□	□
21.Bulimia	□	□	44.Arm Problem	□	□	65.Intolerance to cold temps	□	□
22.Cancer	□	□	45.Shoulder Problem	□	□	66.PMS or menstrual problems	□	□
23.Skin Problems	□	□	46.Kenn Problem	□	□	67.Other	□	□

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE ITEMS, PLEASE EXPLAIN BELOW. INCLUDE THE FOLLOWING:

-What specific symptoms are occurring
-How often symptom/condition occurs
-Date of last occurrence
-How symptom/condition restricts your activity in any way, including your ability to run, lift and climb
-How long symptom/condition lasts
-How you care for symptom/condition

Item #	Detailed Description (Including Restrictions if any)

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ALLERGIES
FOOD RESTRICTIONS

Are you allergic to any types of food? Yes _____ / No _____

If yes, please define allergies _____

Are you a vegetarian? Yes _____ / No _____

If yes, please define restrictions _____

OTHER ALLERGIES
INCLUDING ALLERGIES TO MEDICINES, INSECT BITES/STINGS, ENVIRONMENTAL

NONE ☐ **OR**

Allergy	Reaction	Medication Required

MEDICATIONS YOU ARE CURRENTLY TAKING
LIST ANY MEDICATIONS YOU ARE USING, INCLUDING PSYCHIATRIC AND OVER THE COUNTER MEDICATIONS

NONE ☐ **OR**

Medication	Condition	Dosage	Date Started	Side Effect

NOTE: If you are taking medication(s), bring double amounts in original container(s), with prescription label intact
ALL MEDICATION LISTED MUST ACCOMPANY STUDENT ON COURSE!

Fitness Level: **Excellent** **Good** **Average** **Fair** **Poor**

_____ **Because activities are usually vigouous in the outdoors, you should expect to engage in active participation**
(Initial)

_____ **I certify that I can SWIM: Yes / No**
(Initial)

I realize that my payment is non refundable following the registration deadline and that all information provided is complete and correct.

I realize that I represent Wake Forest University. The safety and welfare of the group and Wake Forest University takes prescedent over individual concerns. Conduct jeopardizing them will not be tolerated and can result in expulsion. I certify that I have read this information and understand the consequences of my actions.

Participant Signature: _____ **Date: _____**