

Colorado State University- Pueblo
Outdoor Pursuits
Medical Information Form

General Information (Please print clearly):

Name: _____ Date (today): _____

Address: _____ Home Phone: _____

_____ Business Phone: _____

Date of Birth: _____ Height: _____ Weight: _____

Gender: Male: _____ Female: _____

PID# _____

Emergency Notification

Address: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Medical History

- | |
|---|
| 1. List any medications that you are currently taking. |
| 2. Do you have any allergies, (circle) Yes No If yes explain. |
| 3. Have you been hospitalized within the past year or for which you are now undergoing treatment. |

yes no

- a.** dizziness, recurrent headaches, or change in level of consciousness
- b.** eye, ear, nose, throat, tonsils, or sinus symptoms
- c.** impairment of sight, hearing, or speech
- d.** chronic cough, bronchitis or asthma, coughing up of blood, or contact with tuberculosis
- e.** chest pain, shortness of breath, palpitation, ankle swelling, heart murmur, heart disease, high or low blood pressure
- f.** reaction to bee stings
- g.** sensitivities/allergies to: horse serum (tetanus antitoxin), sulfa, penicillin, or any other drugs _____
- h.** symptoms relating to the gastro intestinal tract (i.e. diarrhea, recurring abdominal pain, passing of blood, ulcer of stomach or duodenum)
- i.** severe menstrual cramps or menstrual problems; currently pregnant
- j.** albumin, sugar or blood in urine; kidney stone, frequency in urinating, bed wetting, or other urinary difficulties
- k.** . joint, knee or back pain, bursitis, arthritis, sciatica
- l.** muscle or limb weakness, numbness, or tingling
- m.** benign or malignant growth or tumor
- n.** history of diabetes, thyroid imbalance, hypoglycemia
- o.** dietary restrictions (i.e. diabetic, low cholesterol, vegetarian, etc.)
- p.** episodes of depression., anxiety, hysteria, nervousness
- q.** pregnant

Medical Insurance Information

Participants are responsible for medical expenses. Sickness and accident insurance is recommended.

1. Do you have hospitalization or medical insurance? ☐ Y ☐ N
2. Insurance Company: _____
3. Policy #: _____
4. Family Physician: _____
5. Business Phone: _____
6. Address: _____

Swimming Ability

1. Please rate your swimming ability if you are participating in a water-based program.
☐ no ability ☐ some ability ☐ average swimming ability ☐ good swimmer ☐ excellent swimmer
2. Please list current swimming or lifesaving certificates.

Authorization for Emergency Medical Care

I am aware of my past and present health and fitness in relationship to strenuous activity. I will participate in all course activities except for those noted below by myself and/or my physician. Information about any and all prescription drugs that I am currently taking is noted.

Should an accident or emergency occur that renders me unable to communicate, I hereby give permission to the present Outdoor Pursuits staff members to call and communicate with emergency medical personnel, except as noted below. _____

I have completed the above form to the best of my ability with full knowledge that any information with held may create the potential for serious injury or re-injury. My participation in an Outdoor Pursuits program will be determined based on a review of this form by the facilitation team. Failure to submit this form will mean that you may be an observer, rather than a full participant. Regardless of your physical condition, you are expected to pay attention to your body and its physical limitations to select an appropriate level of participation. Failure to complete all portions of this form could result in injury or compound the damage to an existing injury.

Participant Signature: _____ Date: _____

Lead Facilitator Signature: _____ Date: _____

If you are under the age of 18, you are required to obtain the signature of your parent or guardian.

Parent/Guardian Signature: _____ Date: _____

Participant Medical Notes/Comments
