

CONFIDENTIAL HEALTH FORM

This form is essential for your safety and enjoyment of your program. Please take time to fill out completely and accurately. Please return promptly to the address above.

Course Name: _____ Course Date(s): _____

NAME: _____ Male / Female Date of Birth: _____

ADDRESS: _____
Street City State Zip

PHONE: Home (_____) _____ Work (_____) _____

In case of emergency, notify: _____

Relationship: _____ Phone: (_____) _____

Family Doctor: _____ Phone: (_____) _____

Family Dentist: _____ Phone: (_____) _____

Health Insurance Company: _____ Policy #: _____

(If applicable) Auto Insurance Co.: _____ Policy #: _____

MEDICAL HISTORY

Allergies Are you allergic to any of the following? (check if "yes")

Insects _____

Foods _____

Medication (ie. Penicillin, aspirin, sulfa drugs) _____

Environmental _____

Other: _____

If yes to any of the above, please describe your allergic reaction and how you treat it: _____

Diet Do you require a special diet? If yes, please explain:

Tetanus Date of your last tetanus shot _____

Habits Are you a regular user of caffeine, tobacco, alcohol or recreational drugs? Please explain: _____

(please fill out the **back** of this form)

History Do you have a history of (check if "yes" and describe below):

- | | |
|---|--|
| <input type="checkbox"/> heart conditions | <input type="checkbox"/> breathing conditions (including asthma) |
| <input type="checkbox"/> seizures | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> abnormal blood pressure | <input type="checkbox"/> back problems |
| <input type="checkbox"/> stomach problems | <input type="checkbox"/> vision problems (including glasses or contacts) |
| <input type="checkbox"/> knee or other joint problems | <input type="checkbox"/> corrective brace or device |
| <input type="checkbox"/> hearing problems | <input type="checkbox"/> are you pregnant? |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> migraines |
| <input type="checkbox"/> Raynaud's Syndrome | <input type="checkbox"/> dizziness |
| <input type="checkbox"/> frostbite | <input type="checkbox"/> poor circulation |
| <input type="checkbox"/> hypothermia | <input type="checkbox"/> toothaches |
| <input type="checkbox"/> past surgery | <input type="checkbox"/> periods of unconsciousness |

If yes to any of the above, have you been treated? Explain.

Have you taken or do you presently take any medication on a regular basis? If yes, describe: .

Is there anything else that we should know about you? (Phobias, special needs, sensitivities, etc.) .

I have read and understand this form's contents completely and have answered the above questions accurately.

I believe that I/participant am in good physical condition and that I/participant can participate fully in trip activities.

The staff of the UMD Recreational Sports Outdoor Program has my authorization to review and retain this form as protected health information for the purposes of the above program. The staff of the UMD Recreational Sports Outdoor Program has my permission to seek and/or administer emergency care for the participant in the event that the participant or guardian cannot respond at the time of emergency and has authorization to provide this form to health care personnel for the purposes of the participant's emergency treatment in that event. I understand that UMD Recreational Sports Outdoor Program is not responsible for any charges for such health care services provided to the participant.

I understand that I have the right to revoke, in writing, this authorization at any time; however, this authorization will automatically expire at the end of the above program. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the participant's protected health information have acted in reliance upon this authorization. Further, I understand that, if a participant's protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be redisclosed and would no longer be protected.

Date: _____ Signature of participant: _____

Date: _____ Signature of parent/guardian: _____