

SURE FOOT ADVENTURES

Medical Information and Release



Participant's Name _____

Date _____

In case of emergency contact: _____

Relationship _____ Home Phone _____

Work Phone _____ Cell Phone _____

Are you covered by a hospitalization/medical care policy? Yes ___ No ___

Insurance Company Name _____ Policy # _____

Personal Medical History

Do you have, or have you had any of the following conditions or symptoms? Mark every question either Yes or No. Use additional pages if necessary.

	Yes	No		Yes	No
1. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	25. Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	26. Allergy to Iodine	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	27. Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
4. Irregular	<input type="checkbox"/>	<input type="checkbox"/>	28. Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>
5. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	29. Sleep Walking	<input type="checkbox"/>	<input type="checkbox"/>
6. Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	30. Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
7. Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	31. Neck Problem	<input type="checkbox"/>	<input type="checkbox"/>
8. Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	32. Back Problem	<input type="checkbox"/>	<input type="checkbox"/>
9. Blood Disorder/Anemia	<input type="checkbox"/>	<input type="checkbox"/>	33. Arm Problem	<input type="checkbox"/>	<input type="checkbox"/>
10. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	34. Shoulder Problem	<input type="checkbox"/>	<input type="checkbox"/>
11. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	35. Knee Problem	<input type="checkbox"/>	<input type="checkbox"/>
12. Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	36. Ankle Problem	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No		Yes	No
13. Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	37. Leg Problem	<input type="checkbox"/>	<input type="checkbox"/>
14. Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	38. Foot Problem	<input type="checkbox"/>	<input type="checkbox"/>
15. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	39. Currently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
16. Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>	40. Special Diet	<input type="checkbox"/>	<input type="checkbox"/>
17. Circulation problems	<input type="checkbox"/>	<input type="checkbox"/>	41. Medical Equip/Device	<input type="checkbox"/>	<input type="checkbox"/>
18. Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	42. Surgery	<input type="checkbox"/>	<input type="checkbox"/>
19. Head Aches	<input type="checkbox"/>	<input type="checkbox"/>	43. Colds/sores	<input type="checkbox"/>	<input type="checkbox"/>
20. Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	44. Venereal Disease	<input type="checkbox"/>	<input type="checkbox"/>
21. Intestinal Probs.	<input type="checkbox"/>	<input type="checkbox"/>	45. Chronic/Frequent Illness	<input type="checkbox"/>	<input type="checkbox"/>
22. Heatstroke	<input type="checkbox"/>	<input type="checkbox"/>	46. PMS or menstrual problems	<input type="checkbox"/>	<input type="checkbox"/>
23. Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>	47. Recurring diarrhea/constipation	<input type="checkbox"/>	<input type="checkbox"/>
24. Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	48. Other _____		

If you answered YES to any of the listed conditions/symptoms, please explain below. Include specific information about how long the condition lasted, dates of occurrence, and treatment. How do(es) this condition effect your ability to hike, climb, lift, and carry a pack?

Item No. Detailed Description

Insects:

Have you been stung by a bee, hornet, wasp, or yellow jacket before?

YES / NO (circle one)

Are you allergic to any insect bite or sting? If yes, please describe your reaction.

Allergies: Include food, environmental, and drug allergies.

Allergy	Reaction	Medication Required
1.		
2.		
3.		
4.		

Medications: List any medications you take including over-the counter medications.

Medication	Condition	Dose (size and freq.)	Side-Effects?
1.			
2.			
3.			

Hospitalization/Emergencies

Please list any hospital or emergency department visits in the last two years?

Date	Reason	Length of Stay
1.		
2.		

Please describe any other pertinent medical, psychological, or emotional issues that might affect your participation in your Sure Foot trip:

NOTICE: The following is required. Applicants or participants will not be accepted without it:

I _____ (applicant name) hereby give Sure Foot Adventures Staff and Trip Leaders, and Emergency Personnel consent and permission to provide first aid and emergency medical treatment in the event I am injured during an adventure trip. I am aware that this medical information form will be kept with the Sure Foot Lead Guide, and that Sure Foot Adventures Staff and Trip Leaders will take precautions to keep this information confidential. I understand that many participants with a variety of medical/psychological difficulties can successfully complete adventure trips, but it is my responsibility to make the Sure Foot Adventures staff aware of my medical history. I acknowledge and understand that failure to truthfully and accurately disclose the required information in this form could result in serious harm to fellow participants and myself. I understand the rigorous nature of the trip. I understand that professional medical attention could be several hours or several days away. I understand that I will be held responsible for the cost of an evacuation if I require one. I understand the importance of this form and have answered all statements fully and truthfully. I understand that if I am at all uncertain about my ability to participate in this trip it is my obligation to consult my personal physician.

Signature of applicant: _____

Date: _____

Signature of Parent/Guardian: _____

Date: _____

(if applicant is under 18 years of age)