SURE FOOT ADVENTURES

Medical Information and Release

Participant's Name ______________________ **Date** ______________

Birthdate__________________________ Height ____________ Weight ____________

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

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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:

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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)