HEALTH FORM

Confidential

To be filled out by the participant (and parents if the participant is under 18)

Group name _____ **Date of Program** _____

Participant name _____ Birth date ____/____/____

Address _____ Age _____ Sex _____

City _____ State _____ Zip _____

Home or cell phone _____ Height _____ Weight _____

In case of emergency, contact:

Name _____ Relationship _____

Home phone _____ Work phone _____

Name _____ Relationship _____

Home phone _____ Work phone _____

Primary Physician's Information

Physician name _____ Physician's phone number _____

General Medical History

Please circle and explain any of the following conditions (past or present) that could affect your performance and level of comfort in this program:

Yes No Diabetes or thyroid problems (if yes, please contact Outdoor Center for additional information)

Yes No Epilepsy, seizure or convulsions

Yes No Any problems with vision or hearing. Do you use contact or regular glasses?

Yes No Headaches, dizzy spells, fainting, blackouts

Yes No Palpitation of the heart, irregular heartbeat, heart murmurs, or cardiac problems

Yes No Are you pregnant?

Comments on any "Yes" items _____

Muscle/Skeletal Injuries (last 12 months)

Yes No Chronic pain in neck, back, legs, arms, shoulders

Yes No Broken bones, joint dislocations, serious sprains, or weakness of muscles

Yes No Any severe injury to head, chest, or internal organs

Comments on any "Yes" items _____

Allergies

Yes No Any known allergies? ***If yes**, then complete the section below.*

Specify types of allergies (food, medication, insect bites, etc.) _____

Yes No Are you carrying with you an EpiPen® or Epinephrine.

Asthma

Yes No Have you ever had any asthma signs/symptoms? ***If yes**, then complete the section below*

Date of last asthma attack (month/year) _____/_____

What induces your asthma? Please check all that apply.

☐ Exercise ☐ Fatigue ☐ Dehydration ☐ Stress ☐ Food item ☐ Smoke ☐ Allergen:_____ ☐ Respiratory infection/cold ☐ Other:_____

Please explain any box that you checked:_____

_____

Yes No Are you carrying an inhaler with you?

Personal History

Yes No Have you had any recent (within last six months) illnesses, injuries, or operations?

_____

Yes No Do you have any disabilities? _____

Yes No Do you have any fears or phobias? _____

Yes No Are you currently under care of a physician for any reason? Please explain:

_____

_____

Is there any other information we should know?

_____

_____

Release (to be signed by parent(s) or guardian(s) of participants under the age of 18)

Does Texas State have your permission to administer Aspirin, Tylenol or Ibuprofen, during program if necessary? [ ]YES [ ] NO

I hereby authorize and give full consent to Texas State University to act on my behalf in the event I cannot be contacted, to enable prompt care and attention in case of illness or accident incurred by my daughter/son or myself.

Participant Signature _____ Date _____

Parent Signature (if under 18 years old) _____ Date _____