

**Adirondack Community College
Adventure Sports Program
Medical Information Form**

General Information (Please print clearly)

Name: _____ Date (today): _____
 Address: _____ Home Phone: _____
 Business Phone: _____
 Are you? M F Date of Birth: _____ Height: _____ Weight: _____

Medical Information

Family Physician: _____ Business Phone: _____
 Address: _____
 If you do not have a family physician or your physician is unavailable, may ACC appoint a physician to treat you? Y N
 Emergency Notification: _____ Relationship: _____
 Address: _____
 Home Phone: _____ Business Phone: _____

Medical History

1. Date of last Tetanus Booster: _____	2. List medications you are currently taking and for what reasons: _____
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3. Please list allergies, your reactions to them, and required medication below.

Allergies	Reaction	Medication

4. Please list conditions for which you have been hospitalized within the past year or for which you are now undergoing treatment.

Condition	Name & Location of Hospital	Treatment & Date

5. If you now have, or have had any of the following symptoms or conditions, please circle "yes" and underline the specific condition. **If not, circle "no"**. See the lead facilitator if necessary.

- a. **yes no** dizziness, recurrent headaches, or change in level of consciousness
- b. **yes no** eye, ear, nose, throat, tonsils, or sinus symptoms
- c. **yes no** impairment of sight, hearing, or speech
- d. **yes no** chronic cough, bronchitis or asthma, coughing up of blood, or contact with tuberculosis
- e. **yes no** chest pain, shortness of breath, palpitation, ankle swelling, heart murmur, heart disease, high or low blood pressure
- f. **yes no** reaction to bee stings
- g. **yes no** sensitivities/allergies to: horse serum (tetanus antitoxin), sulfa, penicillin, or any other drugs
- h. **yes no** symptoms relating to the gastro intestinal tract (i.e. diarrhea, recurring abdominal pain, passing of blood, ulcer of stomach or duodenum)
- i. **yes no** severe menstrual cramps or menstrual problems; currently pregnant
- j. **yes no** albumin, sugar or blood in urine; kidney stone, frequency in urinating, bed wetting, or other urinary difficulties
- k. **yes no** muscle, joint, knee or back pain, bursitis, arthritis, sciatica
- l. **yes no** muscle or limb weakness, numbness, or tingling
- m. **yes no** benign or malignant growth or tumor
- n. **yes no** history of diabetes, thyroid imbalance, hypoglycemia
- o. **yes no** dietary restrictions (i.e. diabetic, low cholesterol, vegetarian, etc.)

p. **yes no** episodes of depression., anxiety, hysteria, nervousness

q. **yes no** currently pregnant

Please include detail about any medical information that you feel is relevant to your participation in this activity? See the lead facilitator if necessary.

Insurance

1. Participants are responsible for medical expenses. Sickness and accident insurance is recommended.
2. Do you have hospitalization or medical insurance? Y N
3. Insurance Company:
4. Policy #:

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.

Signature

I have completed the above form to the best of my ability with full knowledge that any information withheld may increase the potential for serious injury or re-injury.

Signature:

Date:

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 physician selected by present course staff members to hospitalize and/or secure proper treatment for me, except as noted below.

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:

Your participation in an outdoor adventure 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.

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the student(s) and Adirondack Community College shall respect the confidential nature of all information that they have access to, including but not limited to patients' personal health information provided to them orally, contained in patient medical records or maintained on the College's electronic information system.