OUTDOOR ADVENTURE CENTER MEDICAL RECORD

PART I – GENERAL INFORMATION

Name:_____ Gender:_____
Address:_____ City, State, Zip:_____
Age at Program Start: _____ Date of Birth:_____ Height:_____ Weight:_____
Email Address:_____ Home Phone: _____ Cell Phone:_____

EMERGENCY CONTACT
Name:_____ Relationship:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

FAMILY PHYSICIAN
Name:_____ Phone:_____

HEALTH INSURANCE COMPANY
Name:_____ Phone:_____
Policy Number:_____

ETHNIC BACKGROUND (OPTIONAL)

☐ Asian ☐ Caucasian ☐ American Indian or Alaskan Native ☐ Hispanic or Latino ☐ Multiethnic ☐ African American
☐ Native Hawaiian or Pacific Islander ☐ Unknown ☐ Other

Swimming ability: I am a ☐ Strong Swimmer ☐ Moderate Swimmer ☐ Weak Swimmer ☐ Non-Swimmer

PART II – PAST AND PRESENT MEDICAL PROBLEMS/HISTORY

A. Conditions or Symptoms	Yes	No		Yes	No		Yes	No
1. Seizure Disorder/Epilepsy	☐	☐	10. Vision Impairment	☐	☐	19. Foot Problem	☐	☐
2. Seizure within Past Year	☐	☐	11. Hearing Impairment	☐	☐	20. Special Diet	☐	☐
3. Asthma	☐	☐	12. Broken Bones	☐	☐	21. Food Allergies	☐	☐
4. Prescribed/Used Inhaler	☐	☐	13. Neck Problem	☐	☐	22. Cold Injuries	☐	☐
5. Hypoglycemia (low blood sugar)	☐	☐	14. Back Problem	☐	☐	23. Heat Injuries	☐	☐
6. Allergies	☐	☐	15. Elbow/Wrist/Hand Problem	☐	☐	24. Recent Surgery (last 5 years)	☐	☐
7. Prescribed/Used Epinephrine	☐	☐	16. Shoulder Problem	☐	☐	25. Require Regular Medication	☐	☐
8. Currently Pregnant	☐	☐	17. Knee Problem	☐	☐	26. Documented Disabilities	☐	☐
9. Motion Sickness	☐	☐	18. Leg/Hip Problem	☐	☐	27. Other (please describe below)	☐	☐

B. Cardiac Risk Factors	Yes	No		Yes	No
28. Squeezing/Tightness in chest during Exercise	☐	☐	32. Family History Heart Disease /Issues	☐	☐
29. High Blood Pressure/Medication	☐	☐	33. Tobacco Use in any form	☐	☐
30. Exercise less than 1x week	☐	☐	34. Male over 45 years of Age	☐	☐
31. Diabetes	☐	☐	35. Female over 55 years of Age	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE ITEMS, PLEASE EXPLAIN BELOW. INCLUDE THE FOLLOWING:

- What specific symptoms are occurring
- Date of last occurrence
- How you care for symptom/condition
- Medications you are taking-purpose of each-dosage/frequency
- How often symptom/condition occurs
- How long symptoms/condition lasts
- How symptom/ condition restricts your activity in any way, including your ability to run, lift, climb or carry

ITEM#	DETAILED DESCRIPTION (INCLUDE RESTRICTIONS IF ANY)

PART II — PAST AND PRESENT MEDICAL PROBLEMS/HISTORY (CONTINUED)

C. OTHER CONSIDERATIONS

What other medical, behavioral or psychological factors should we know about you before you start this program?

PART III – DISCLOSURE

- The information provided on this form is a complete and accurate statement of the physical and psychological factors which may affect my participation on an OAC program.
- I agree to be responsible for any and all costs associated with such treatment, including the costs of evacuation, if any.
- I understand that I may be in remote areas, several hours or days away from any medical facility or where communication, transportation or evacuation is subject to delay.
- If you arrive at the program start with a pre-existing medical, behavioral or psychological condition which is not indicated on your medical form and you are subsequently unable to participate fully or are forced to leave the program because of that condition, you will forfeit tuition and may be charged an evacuation fee.
- I believe that I am in good health, and affirm that my participation in this/these OAC activities will in no way aggravate any present condition. If I have three or more cardiac risk factors I understand I will be required to receive written approval from a physician before being allowed to fully participate. If in doubt I will seek and follow medical advice.
- I realize that failure to disclose information could result in serious harm to me and other participants. I agree to hold harmless the OAC and The Ohio State University form any liability, claim, or expense resulting, directly or indirectly, from my failure to disclose relevant information. This information will be kept confidential except as needed in an emergency.
- I hereby consent to first aid treatment and evacuation, and to treatment, anesthesia, and/or operations in a medical facility should that become necessary in the event of a medical emergency while participating in an OAC activity. In case of treatment, I consent to the release of medical records and accident report forms to insurance companies or agencies deemed appropriate by the OAC.

Participant's Signature

Today's Date

Parent or Guardian Signature if under 18

Today's Date

Reviewed By: