

Health History



Please Print

Name:	Date:
Outing Name:	

This trip involves participation in activities which are, by nature, physically demanding, and often times take place remote in locations without the opportunity for immediate medical attention. As a participant of an Outdoor Adventure Trip we require full disclosure of your current health. The information you provide is essential, as it may assist with your care in the event of an accident. Full and accurate completion of all sections is very important. The provided information will be kept confidential between the trip leader(s), and health care professionals in the event of an accident. This form is not used to evaluate your ability to participate in any activities. Only qualified health care professionals can make that decision.

Gender: M F	Age:	Height:	Weight: lbs
Address:		Phone	
		Cell:	
		Work:	
		Other:	

Emergency Contact Information

Name:	Relationship:	
Address:		
Phone		
		Cell:
		Work:
		Other:
Family Physician:	Phone:	

Medical Insurance Information

Each participant is strongly encouraged to be covered by his/his own health insurance. The University of Akron, Recreation and Wellness Services, and Outdoor Adventure Services do not provide sickness, health, or accident insurance

Insurance Provider:	Policy/Group #:
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- Do you have any physical disabilities or conditions that might limit your participation? Yes No
 If yes please describe. _____
- Are you currently under treatment for any illness or medical condition? Yes No
 If yes please describe. _____
- Do you regularly take or need to carry medications? Yes No
 If yes please list and describe. _____
- Do you have any allergies? Yes No If yes please list and describe. _____
- Are you allergic to bee or insect stings? Yes No If yes please describe your allergic reaction. _____
If you require medications for allergic reactions please bring two doses with you and alert your instructor(s).
- Have you had a cold injury? Yes No Have you had a heat injury (i.e. exhaustion)? Yes No
 If yes please describe. _____
- Do you have a history of heart problems? Yes No If yes, please explain. _____
- Have you every undergone surgery within the past year? Yes No . Do you have any open wounds? Yes No
 If yes, please explain. _____
- Do you have any dietary restrictions (gluten, dairy, vegetarian, etc.)? Yes No Please list. _____
- Do you smoke? Yes No Do you wear glasses/contacts? Yes No Do you have dentures/false teeth? Yes No
- Can you swim? Yes No Are you First Aid/CPR certified? Yes No exp. _____