

Shenandoah Outdoor & Adventure Recreation Health and Medical Form

All persons attending SOAR trips are required to fill out a Health and Medical Form. By completing the information below, you will assist medical personnel in caring for you. As a participant in a Shenandoah University program you may encounter a health emergency requiring hospitalization and/or immediate medical care and treatment. The trip leader will retain a copy of this permission statement and medical information.

General Information:

Full name: _____ SU ID #: _____

Address: _____

Phone number: _____ Email: _____

Date of birth: _____ Age: _____ Gender: _____

Emergency Contact:

Full Name: _____ Relationship to me: _____

Address: _____ Phone number: _____

Medical Information:

Allergies (Including medicines, foods, bites, stings). _____ NONE (initial here if you have none)

Allergy Reactions (what happened) Medication Required

Medications _____ NONE (initial here if you have none)

Medication Condition Dosage (amt. and frequency) Side Effects

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Health History (please circle all that apply and describe in the area provided if circled)

1. Pregnant
2. Requires Medical Equipment
3. Hospitalization/emergency room visit within the past year
4. Surgery within the last year
5. Neck/back/shoulder/knee/ankle problems
6. History of heart attack or other heart problems
7. Diabetes, NIDDM or IDDM
8. Elevated blood cholesterol or triglycerides?
9. Hypertension
10. History of seizures
11. Anemia
12. Respiratory Issues Do you smoke? _____ Yes _____ No

If you answer yes to any question above or have any other important health history, please provide a detailed description including symptoms and restrictions.

Permission for Emergency Treatment:

In the event of an emergency, illness or injury affecting me (**print name**)

_____, **born (date)** _____, I, the

undersigned, hereby authorize immediate hospitalization and treatment recommended by and carried out under the supervision of a qualified physician or other medical personnel, including but not limited to administering an anesthetic and performing necessary surgery. I understand such treatment may be solely at my expense, or may be covered by my personal insurance.

In the event of a medical emergency, as a participant, if I am unable to make my own medical decisions, I understand the trip leader would be authorized, but not liable, to make medical decisions on my behalf.

To my knowledge, the information on this form is accurate.

My name (print) Signature Date

If I am under the age of 18; my parent/guardian signature is required (above).