# Health and Medical Disclosure Form

*Nothing should be left blank – put N/A if not applicable

PRIVACY ACT STATEMENT

Authority: 10 USC 8013: 44 USC 3101: EO 937

PRINCIPLE PURPOSE; To provide the Outdoor adventure Program with authorization for medical treatment in emergency situations; authorizations for field trips; identify children, sponsors, and participants; record relevant health and fitness conditions; record known allergies; record illness or injuries; record current medications; record special needs requirements; and record special instructions.

ROUTINE USES; Form may be furnished to civilian or military doctors; and hospitals in course of obtaining emergency medical attention. Information furnished may be disclosed, upon request, to other Federal, State, or Local Governmental Ardencies in the pursuit of their official duties. Finally, It may be used for other lawful purposes including law enforcement litigation.

DISCLOSURE IS VOLUNTARY; Failure to furnish information will result in denial of admission of persons to Outdoor Adventure Programs.

| | | |
|---|---|---|
| Name: | | Age: Sex: |
| Address: | | Height: Weight: |
| City: | State: | Zip: |
| Home: | Cell: | Work: |
| Sponsor's Name: | | Rank: |
| Emergency Contact Name: | | Phone: |
| Local Contact Name (if different): | | Phone: |

Please answer the following questions to the best of your ability. The information that you can provide will help inform professionals in the event of an emergency, i.e. Emergency Medical Professionals, Police, etc.

**Present physical condition**

Statement on description of present fitness level on a scale from 1 (low) to 10 (high):

| |
|---|
| |

**Allergies**

Please include an allergic reaction to insect bites, bee or wasp stings, or medications resulting in hives, swelling of face/lips or difficulty breathing.

| Allergy | Reaction | Medication Required (if any) |
|---|---|---|
| | | |
| | | |

**Current Medications**

Please list all prescription medications, over the counter medications, and/or drugs you are currently taking:

| Medication | Taken for (Condition?) | Dosage | Date Started | Current Side Effects |
|---|---|---|---|---|
| | | | | |
| | | | | |

***COMPLETE OTHER SIDE***

**Current or past issues relating to**

(Please check Yes or No. If yes, please explain in area below)

| MEDICAL | | |
|---|---|---|
| **Yes** | **No** | |
| | | Diabetic |
| | | Seizures or Epilepsy |
| | | Angina or Heart Condition |
| | | Cardiac abnormality (murmur) |
| | | Blood Disorder |
| | | Raspatory Issues or Asthma |
| **PERSONAL** | | |
| **Yes** | **No** | |
| | | Motion sickness |
| | | Dizziness/Fainting spells |
| | | Gastrointestinal disturbance |
| | | Unexplained shortness of breath |
| | | Currently (or chance of) pregnant |
| | | Smoke |
| | | Able to swim |
| | | |

| MUSCULOSKELETAL | | |
|---|---|---|
| **Yes** | **No** | |
| | | Rupture/Hernia |
| | | Stomach/Intestinal/Ulcers |
| | | Neck/Back/Shoulder/Knee/Ankle injury |
| | | Swollen/Painful Joints |
| **ENVIRONMENTAL** | | |
| **Yes** | **No** | |
| | | Cold injury or frostbite |
| | | Heat injury or heatstroke |
| | | Seasonal allergies/Hay Fever |
| | | Altitude related issues (AMS/HACE/HAPE) |
| **PSYCHOLOGICAL & EMOTIONAL** | | |
| **Yes** | **No** | |
| | | PTSD/TBI |
| | | Depression |
| | | Eating disorder |
| | | Substance abuse (drugs/alcohol/meds) |

If yes, please explain.

List any medical problems, illness, injuries, or chronic conditions other than those already noted.

Are there any other issues you feel may affect your ability to safely participate in this program or that we should be aware of?

I CERTIFY THAT I HAVE REVIEWED THE FOREGOING INFORMATION, AND THAT THE INFORMATION CONTAINED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

I UNDERSTAND THAT I AM RESPONSIBLE FOR THE USE AND CARE OF ANY PERSONAL MEDICATIONS AND/OR MEDICAL REQUIREMENTS.

I UNDERSTAND THAT THE INFORMATION CONTAINED WITHIN THIS DOCUMENT IS PROTECTED UNDER THE PRIVACY ACT. IN SIGNING, I AUTHORIZE THE OUTDOOR ADVENTURE PROGRAM TO RELEASE THIS INFORMATION TO MILITARY AND CIVILIAN HEALTH CARE PROFESSIONALS; LAW ENFORCEMENT; AND OTHER GOVERNMENT AGENCIES ACTING IN PURSUIT OF CARE AND ATTENTION IN EMERGENCY HEALTH AND SAFETY SITUATIONS.

Signature: _____ Date:_____

Parent Signature (if participant is a minor):_____ Date:_____