ADVENTURE TRIP PROGRAM
HEALTH FORM

Confidential

To be filled out by the participant (and parents if the participant is under 18)

Trip name _____ **Date(s) of Program** _____

Participant name _____ Birth date ____/____/____

Address _____ Age _____ Sex _____

City _____ State _____ Zip _____

Home or cell phone _____ Height _____ Weight _____

In case of emergency, contact:

Name #1 _____ Relationship _____

Primary phone _____ Work phone _____

Primary Physician's Information

Physician name _____ Physician's phone number _____

Insurance Information

Insurance Provider: _____ Policy #: _____

General Medical History

Please circle and explain any of the following conditions (past or present) that could affect your performance and level of comfort in this program:

Yes☐No☐ Diabetes or thyroid problems

Yes☐No☐ Epilepsy, seizure or convulsions

Yes☐No☐ Any problems with vision or hearing. Do you use contacts or glasses?

Yes☐No☐ Headaches, dizzy spells, fainting, blackouts

Yes☐No☐ Palpitation of the heart, irregular heartbeat, heart murmurs, or cardiac problems

Yes☐No☐ Are you pregnant?

Yes☐No☐ Have you had any major injuries, illnesses or operations within the last 12 months?

Comments on any "Yes" items _____

Muscle/Skeletal Injuries (last 12 months)

Yes ☐ No ☐ Chronic pain in neck, back, legs, arms, shoulders

Yes ☐ No ☐ Broken bones, joint dislocations, serious sprains, or weakness of muscles

Yes ☐ No ☐ Any severe injury to head, chest, or internal organs

Comments on any "Yes" items _____

Allergies

Yes☐No☐ Any known allergies? ***If yes**, then complete the section below.*

Specify types of allergies (food, medication, insect bites, etc.) _____

What is your usual reaction when exposed to this type of allergen? _____

_____

Yes☐ No☐ Have you ever had or been treated for anaphylactic shock?

Yes☐No☐ Do you carry an EpiPen® or epinephrine? *Note: TCU Staff **DO NOT** carry EpiPen® or epinephrine. If you have ever experienced anaphylaxis, you are **REQUIRED** to carry an EpiPen with you on this trip.*

Asthma

Yes☐No☐ Have you ever had any asthma signs/symptoms? ***If yes**, then complete the section below*

Date of last asthma attack (month/year) _____/_____

What induces your asthma? Please check all that apply.

☐ Exercise ☐ Fatigue ☐ Dehydration ☐ Stress ☐ Food item ☐ Smoke ☐
Allergen:_____ ☐ Respiratory infection/cold ☐ Other:_____

Please explain any box that you checked:_____

Yes☐ No☐ Are you carrying an inhaler with you?

Personal History

Yes☐No☐ Do you have any disabilities? _____

Yes☐No☐ Do you have any fears or phobias? _____

Yes☐No☐ Are you currently under care of a physician for any reason? Please explain:

_____

Yes☐No☐ Are you currently taking any medications? If so, please list: _____

_____

Yes☐No☐ Do you exercise on a regular basis? How often? _____
Yes☐No☐ Do you smoke? If yes, how much? _____

Is there any other information we should know?

_____

Does Texas Christian University have your permission to administer Aspirin, Tylenol or Ibuprofen, during the program if necessary? ☐YES ☐ NO

I hereby authorize and give full consent to Texas Christian University to act on my behalf in the event I cannot be contacted or am incapacitated, to enable prompt care and attention in case of illness or accident incurred by my daughter/son or myself.

Participant Signature _____ Date _____

Parent Signature (if under 18 years old) _____ Date _____