



# Health History High Adventure / Wilderness Hiking / Backpacking

(To be completed by Parent/Guardian or Adult Participant. Please use black or blue ink.)

Participant's name \_\_\_\_\_ Date of birth \_\_\_\_\_ Marital Status \_\_\_\_\_

Physical address \_\_\_\_\_ Mailing address \_\_\_\_\_

Daytime phone (\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

In an emergency notify \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime phone (\_\_\_\_) \_\_\_\_\_ Evening phone (\_\_\_\_) \_\_\_\_\_ E-mail \_\_\_\_\_

Family physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ Family dentist \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Family medical/hospital insurance carrier \_\_\_\_\_ Policy or group # \_\_\_\_\_

**In order to better serve the needs of participants in the High Adventure Activity, it is imperative that all medical information is documented below.**

### Chronic illness

- Epilepsy/seizures
- Eating disorder
- Heart disease
- Asthma
- Diabetes
- Sickle cell anemia
- Hearing impairment
- Recent infections \_\_\_\_\_

### Other health conditions (check all that apply)

- Frequent headaches
- Nosebleeds
- Stomach upsets
- Constipation/diarrhea
- Altitude Sickness
- Motion sickness
- Emotional disturbance
- Menstrual problems
- Fainting
- Wears glasses/contacts

### For overnights only

- Sleep walking
- Night terrors
- Bed-wetting

Allergies (specify) \_\_\_\_\_

Date of last health examination: \_\_\_\_\_ Other (specify) \_\_\_\_\_

Were any complicating medical problems noted? \_\_\_\_\_

Medication: Is the participant currently taking prescription/over the counter medication?  Yes  No

If yes, please explain. \_\_\_\_\_

Has the participant been on prescription medication within the last three months?  Yes  No

If yes, please explain. \_\_\_\_\_

List past medical treatment such as operations, treatment for serious injuries, diseases or disabilities, hospitalizations and dates: \_\_\_\_\_

List any key outdoor concerns (e.g., fear of heights, stream crossings, snow): \_\_\_\_\_

**Immunization History:** Are immunizations up to date? Y  N  Hepatitis A: Yes  No  Chicken Pox: Yes  No

Date of last tetanus shot \_\_\_\_\_

### Is the participant currently:

- under a physician's care
- receiving psychological counseling
- restricted in physical activity

### In the last year, has there been incident of:

- hospital treatment
- an injury/illness requiring medical attention
- an illness lasting longer than 5 days
- a surgical operation or fracture
- exposure to contagious disease

Please explain any items that are checked. Indicate any information useful to the adult in charge in relation to High Adventure Activity events: \_\_\_\_\_

\_\_\_\_\_ I have been informed that this trip involves certain risks. I have been made aware of the effects of high altitude and the risks involved with climbing to an altitude of over 8,000 feet. I have read the materials provided regarding altitude risks and sickness and approve my minor child to participate in this activity. **(Must be initialed for all girls and adults participating in high altitude climbing.)**

This health history is complete and accurate. I know of no reason(s) other than the information indicated on this form, why my minor child/I should not participate in a High Adventure Activity (Wilderness Hiking/Backpacking Beginning or Advanced/Rock Climbing, etc.). If any incident occurs that may have impact on the health or safety of my child/myself while participating in High Adventure Activity, I will notify the leader in charge in advance of the event. I understand that this event may take place more than 2 hours from definitive medical care and that it may be necessary to provide emergency attention before medical help arrives.

**As the parent of a minor participant, I give my permission for the adult in charge to take my child to a medical facility for treatment. As an adult participant, I give my permission to be taken to a medical facility for treatment. In case of emergency, if none of the above can be contacted, I, the undersigned, consent to allowing treatment under the supervision of and as deemed advisable by a physician licensed under the Medicine Practice Act. This provides authority pursuant to Section 25.8 of the California Civil Code.**

Parent of Minor/Adult Participant signature \_\_\_\_\_ Date \_\_\_\_\_

A new High Adventure Health History form must be completed every two years. If this is the 2nd year, please check, date and initial your option:

\_\_\_\_\_ I have reviewed the above information and there are no changes in my health history (initial and date) \_\_\_\_\_

\_\_\_\_\_ I have made changes above to reflect my current health history (initial and date) \_\_\_\_\_