



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) _____