Georgia College
Outdoor Education
Medical Information Form

General Information (Please print clearly)

Full Name:	Preferred Name:
Phone:	Date of Birth:
Street Address:	Gender:
	Height: _____ feet _____ inches
City/State/Zip:	Weight: _____ pounds

Contact Information

Emergency Notification:	Relationship:
Street Address:	Phone:
City/State/Zip:	Alternate Phone:
Physician:	Street Address:
Phone:	City/State/Zip:

Insurance

Participants are responsible for medical expenses. Medical insurance is highly recommended, but not required to participate in Outdoor Education programs. Do you have medical insurance? ☐ Yes ☐ No
Insurance Company:
Policy #'s (group and/or member):

Swimming Ability

If you are participating in a water-based program, please rate your swimming ability.
☐ non-swimmer ☐ recreational swimmer ☐ competitive swimmer

Medical History (provide additional information on the back of this form as needed)

Date of last Tetanus Booster:		
Please list any medications (prescription, over the counter, or supplement) you are currently taking and for what reasons:		
Medication	Reason Taken	Dosage (amount & frequency)
Please list any allergies (including medicine, food, and environmental), your reaction to them, and required medication/treatment if exposed.		
Allergies	Reaction	Medication/Treatment Required
Please list conditions for which you have been hospitalized within the past year or for which you are currently undergoing treatment.		
Condition	Treatment Center/Provider	Date & Treatment

PRINT NAME_____

If you now have, or have had any of the following symptoms or conditions, please **circle "yes"** and underline the specific condition. **If not, circle "no"**. See the Lead Facilitator if necessary.

a. **yes** **no** Have you experienced an asthma attack at any time in your life?
b. **yes** **no** Have you ever been diagnosed with type I or type II diabetes?
c. **yes** **no** Have you ever visited a medical professional for a serious allergic reaction, or have you ever been given a shot of epinephrine for an allergy or anaphylaxis?
d. **yes** **no** Have you ever received medical treatment for angina, a heart attack, any type of heart disorder/disease, or high blood pressure?
e. **yes** **no** Have you ever seen a medical professional following a seizure, or are you currently being treated for any type of seizure disorder?
f. **yes** **no** Have you had broken bones or joint injuries that cause recurring problems?
g. **yes** **no** Are you currently pregnant?
h. **yes** **no** History of cold (hypothermia, frostbite, Raynaud's Syndrome), heat (heat stroke), or altitude (AMS, HAPE/HACE) injuries or illnesses
i. **yes** **no** Eye, ear, nose, throat, tonsils, or sinus symptoms
j. **yes** **no** Impairment of sight, hearing, or speech
k. **yes** **no** Heart Murmur, Irregular Heartbeat/Palpitations, Chest Pain/Pressure, Circulation Problems, Bleeding/Blood Disorder, Sickle Cell Anemia or Sickle Cell Trait
l. **yes** **no** Respiratory problems including COPD, chronic cough/bronchitis, or contact with tuberculosis
m. **yes** **no** Frequent Dizziness/Fainting, Vertigo, Motion Sickness, Migraines/Severe Headaches, Head Injury w/Neurological Impairment, muscle or limb weakness, numbness, or tingling
n. **yes** **no** Gastro-intestinal Problems (i.e. diarrhea, recurring abdominal pain, passing of blood, or ulcer)
o. **yes** **no** Severe menstrual cramps or menstrual problems
p. **yes** **no** Kidney Problems, Urinary Tract Problems, or Bedwetting
q. **yes** **no** Cancer, benign or malignant growth or tumor
r. **yes** **no** Thyroid imbalance, hypoglycemia, Active or History of Hepatitis or other liver disease
s. **yes** **no** Dietary restrictions (i.e.: diabetic, low cholesterol, vegetarian, etc.)
t. **yes** **no** Mental health disorders (i.e. ADHD, anxiety, autism spectrum, bipolar, depression, eating, obsessive-compulsive, post-traumatic stress, etc.)
u. **yes** **no** Have you been diagnosed with any other medical condition or asked by your physician to limit your activities in any way?

Please include detail about any medical information that you circled **yes** for or may be relevant to your participation in this activity. See the Lead Facilitator if necessary**.**

I have completed this form to the best of my ability with full knowledge that any information withheld may increase the potential for serious injury or reinjury. I am aware of my past and present health and fitness for doing strenuous activity. I will only participate in program activities that I believe I can participate in safely. I will not participate in any activities that my physician has recommended against. Should an accident or emergency occur that renders me unable to communicate, I hereby give permission to the physician selected by Outdoor Education staff to hospitalize and/or secure proper treatment for me. Outdoor Education reserves the right to limit participation in its programs based on information submitted on this form.

Participant Signature	Date
If you are **under the age of 18**, you are required to obtain the signature of a parent or guardian.	
Parent/Guardian Signature:	Date:
Lead Facilitator Signature:	Date:
Participant Review (Date & Initial) _____ _____ _____ _____ _____	
Facilitator Review (Date & Initial) _____ _____ _____ _____ _____	