into the wilderness

Health History / Consent Form

INTRODUCTION / INSTRUCTIONS:

To Parent/Guardian/Participant: We desire every participant at ITW to have a successful experience. However, in the event of an accident occurring we need certain information to be available. When you or your child attends ITW, the following information is needed: 1) Medical history and 2) Medical insurance information. Parent/Guardian/Participant is to complete SECTIONS 1,2, and 3. **It is strongly recommended that a physician complete SECTION 4 if any conditions have been indicated in SECTION 2.**

Diabetes: Insulin-dependent diabetics should bring two times the regular supply of treatment materials needed for the duration of their stay at ITW. Diet and physical exertion may require the alteration of regular treatment methods. Diabetics who have been diagnosed in the last 12 months, who have experienced a hypoglycemic crash or instability within the last 6 months, whose condition is incompletely controlled, or who have changed method of intake (i.e. insulin pump) in the past 6 months will not be allowed to participate in a wilderness experience at ITW.

Asthma: Participants with asthma should be able to control their condition restoring normal lung function. Bronchodilators must be brought by asthmatic individuals and carried with them at all times on all activities engaged in at ITW; also, twice the normal amount of medication should be brought. Asthmatic individuals who have been hospitalized in the past 6 months or who have experienced anaphylactic symptoms (e.g. difficulty breathing, low blood pressure, facial changes such as tongue swelling) will not be allowed to participate in wilderness activities at ITW.

SECTION 1 – Identification, Emergency Contact

Adventure Name: _____ **Group Leader:** _____ **Date of Trip:** _____

Participant Name: _____
Last First Middle

Address: _____
Street City Prov. Zip Code.

Age: _____ Birth Date: _____/_____/_____ Sex _____ Height _____ Weight _____

Name of Dentist/Orthodontist: _____ Phone: _____

Name of Physician: _____ Phone: _____

In Case of Emergency Notify:

Name: _____ Relationship: _____

Address: _____ Email: _____

City/ State/ Zip: _____

Phones: (Home) _____ (work) _____ (mobile) _____

Alternate Contact 1: _____ Relationship: _____ (phones) _____

Alternate Contact 2: _____ Relationship: _____ (phones) _____

SECTION 2 -- Health History

Are you now or have you ever been treated for any of the following? If yes, check box, give date & provide specific details below:

	Condition	Date		Condition	Date		Condition	Date
[ ]	Bleeding Disorders	_____	[ ]	Fainting Spells	_____	[ ]	Diabetes	_____
[ ]	Clotting Disorders	_____	[ ]	Abdominal Problems	_____	[ ]	Asthma	_____
[ ]	Seizures	_____	[ ]	Heart Trouble/Disease	_____	[ ]	Surgeries	_____
[ ]	Hypertension	_____	[ ]	Mental Problems	_____	[ ]	Sickle Cell Anemia	_____
[ ]	Eating Disorders	_____	[ ]	Emotional Distress	_____	[ ]	Other _____	_____

If you have checked any of the above boxes or are concerned about your medical, physical, or emotional well being, we strongly suggest you consult a physician (Section 4) before attending. It is your responsibility to determine if you are able to undertake these activities.

(Use additional paper and attach if necessary)

Specific and full details on any conditions above: _____

_____

_____

Allergies to any medications: _____

Allergies to food, insect bites, plants, other: _____

Have you had more than a brief minor illness (24 hours or more) or injury during the past year? If so, what and when? _____

_____

Serious injuries (dislocations, fractures, strains, sprains) or hospitalizations to date, any reason (date/detail): _____

_____

Any loss of consciousness, traumatic or otherwise (date/detail): _____

_____

Serious operations to date (date/detail): _____

_____

Chronic or recurring illness, including mental illness (date/detail): _____

_____

All medications prescribed and over-the-counter currently taken (include dosage): _____

_____

Dietary restrictions:_____
Restricted activities (detail): _____
_____
Has it ever been necessary to restrict participant's activities due to medical reasons? ___ Yes ___ No Does participant take medicine regularly or have special care? ___ Yes ___ No If YES, explain: _____

SECTION 3 – Authorization for Participation from Parent/Guardian/Participant

_____

The health history is correct so far as I know, and the person herein named has permission to engage in all activities unless specified under "Restricted Activities". I testify that my child is of good physical and mental health and is capable of participation in the activities for which he has applied, which may include whitewater rafting, rock climbing, hiking, ropes course, backpacking, canoeing, rappelling or mountain climbing.

I hereby give permission for transportation to any medical facility or hospital and I authorize any guide or medical personnel to render emergency medical care for my family or myself. I hereby authorize the release of any medical information in the possession of *ITW* to any medical facility, hospital, ambulance, first aid provider, first aid service, doctor, nurse or other such person rendering care on my behalf. I hereby waive any action or claim against *ITW.* or any health care provider, hospital, doctor, nurse or first aid provider for the release of this medical information.

I understand that *ITW* does not provide accident insurance. I understand that it is suggested that I check my insurance policy to make sure accidents occurring on trips with *ITW* are covered by my insurance.

I further understand that *ITW* reserves the right to refuse any person it judges to be incapable of meeting the rigors and requirements of any activity for any reason.

Parent / Guardian Signature: _____ **Date:** _____

2nd Parent / Guardian Signature: _____ **Date:** _____

Participant Signature: _____ **Date:** _____

INSURANCE COMPANY _____ **Group #** _____ **Policy #** _____

SECTION 4 – Physician's Evaluation (recommend to be completed if conditions named in Section 2 were indicated)

To Physician: Participants at ITW will engage in strenuous activities during their stay. These can include, but are not limited to, rock climbing, rappelling, ropes course, whitewater rafting, and hiking or backpacking. Backpacking can involve hiking 4- 12 kilometers a day and carrying a 15 - 20 kilo packs in rugged wilderness terrain ranging from 1,500 meters to over 4,000 meters in elevation. **Please complete the following:**

_____ Height _____ Weight (suitable for activities) _____ BP _____ Pulse

Does the participant have epilepsy? ___ Yes ___ No
Does the participant have diabetes? ___ Yes ___ No
Does the participant have asthma? ___ Yes
If yes, is diabetes under control? ___ Yes ___ No

Recommendations (explain any restrictions OR limitations):_____
_____
_____
_____
Any allergies? _____
_____
Any treatment and/or medication to be continued while at ITW? _____
_____
Any medically prescribed meal plan or dietary restriction? _____
_____
Additional health information _____
_____
In my opinion, the condition of the named participant does not preclude his/her participation in the adventure activities at ITW.

Physician's Name:_____

Physician's Signature: _____ Date:_____ Phone Number: _____

Date of form completion: _____ By * _____

* if form is completed by nurse or physician assistant