

University of San Diego Outdoor Programs

Health Statement & Permission to Treat

Please complete the following information accurately and truthfully. The information you provide will be kept confidential and will be used only for emergency prevention and response. Failure to disclose information could result in an injury, or compound the damage of an injury, to you or to others.

PERSONAL INFORMATION

Name _____ ID# _____ SSN _____

Local Address _____ City/State _____ ZIP _____

Local Phone _____ Cell Phone _____ Email _____

D.O.B _____ M / F Height _____ Weight _____

Health Insurance Company _____ Policy Number _____

Emergency Contact #1 _____ Relationship _____ Home Phone _____

Emergency Contact #2 _____ Relationship _____ Home Phone _____

HEALTH STATEMENT By signing below, I represent that I understand the physical demands of the Outdoor Programs activities, that I may be exposed to a variety of extreme environmental conditions, and that I am in good physical health and condition, am a competent swimmer, and am able to participate in Outdoor Programs (OP) activities and in all aspects of the outing/activity for which I am signing up.

HEALTH INSURANCE AND PERMISSION TO TREAT I have adequate insurance to cover any injury or damage I or my child may cause or suffer while participating in OP activities. I authorize OP personnel to obtain or provide medical care for me or for my child, or to transport me or my child to a medical facility or hospital if, in the opinion of such personnel, medical attention is needed. I further authorize medical personnel, including OP staff, to render such treatment as is necessary, in their opinion, for my health or that of my child. I agree that OP has no responsibility for medical care provided to me or my child once someone with a higher degree of medical training has assumed care, or following delivery to a medical facility or hospital, and I agree to pay all costs associated with such medical care and transportation/evacuation.

ALL QUESTIONS MUST BE ANSWERED: IF THE FOLLOWING QUESTIONS DO NOT PERTAIN TO YOU, WRITE "NO" OR "NONE" IN THE AREA UNDER THE QUESTIONS.

MEDICAL HISTORY

1. Please list any previous/recent or existing/chronic medical conditions (e.g. physical and/or mental disabilities, injuries or illnesses) that could limit your participation **in any way**. How do these affect your daily life?
2. Please list any previous or existing allergies (e.g. trees, pollens, molds, foods, insect stings, medications, etc.). Have you been hospitalized because of an attack? Do you have medication to control the reaction? If so, what kind?
3. Do you suffer from asthma? If so, what triggers it (e.g. exercise, temperature, pollens, etc.)? Are you taking medications to control it? If so, what kind?
4. Please list any medications you are currently taking (e.g. over-the-counter, prescription, birth control, etc.). Are you experiencing any problems as a result of this medication? Are there side-effects we should be aware of (e.g. increased susceptibility to heat and/or light, etc.)?

Participant

Parent/Guardian (if under 18)

7/12/06