

Outdoor Pursuits Medical History Form

Participation in an Outdoor Pursuits class or activity requires that all medical information below be completed and submitted to the BOP Office. This information is needed to provide better first aid and emergency medical care should that be necessary. All information is reviewed upon submission and remains confidential. After review, you may be asked to provide appropriate physician documentation prior to beginning activity or at any time in the future as necessary. Please answer **ALL** questions as completely and accurately as possible.

Name (Please Print): _____ Class Status: Fr. Soph. Jr. Sr. Grad. Other

Date of Birth: _____ Sex: M ___ F ___ Height: _____ Weight: _____

Person to be contacted in case of emergency: _____

Phone (daytime): _____ (Evening): _____ Relationship: _____

Address: _____ City: _____ State & Zip: _____

	Yes	No		Yes	No
Allergy			History of concussions:	<input type="checkbox"/>	<input type="checkbox"/>
Drugs:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease or		
Food:	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever:	<input type="checkbox"/>	<input type="checkbox"/>
Environmental:	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations:	<input type="checkbox"/>	<input type="checkbox"/>
Insects:	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure:	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			<i>Respiratory Problems</i>		
Diabetes:	<input type="checkbox"/>	<input type="checkbox"/>	Asthma:	<input type="checkbox"/>	<input type="checkbox"/>
Disease or Injury of			Cough:	<input type="checkbox"/>	<input type="checkbox"/>
Back, Joints:	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose Throat		
Dizziness, Fainting:	<input type="checkbox"/>	<input type="checkbox"/>	Trouble:	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Problems			Seizure Disorder:	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety (frequent):	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath:	<input type="checkbox"/>	<input type="checkbox"/>
Depression (frequent):	<input type="checkbox"/>	<input type="checkbox"/>	Surgery _____		
Insomnia:	<input type="checkbox"/>	<input type="checkbox"/>			
Head Injury with					
Unconsciousness:	<input type="checkbox"/>	<input type="checkbox"/>			

Has your physical activity restricted during the past five years?
 (Give reasons and durations) Yes _____ No _____

Have you received treatment or counseling for a nervous condition,
 personality or character disorder or emotional problem? (Give details below) Yes _____ No _____

Are you now under treatment for any medical or emotional condition? Yes _____ No _____

Are there any restrictions on physical activity related to classes or sports? Yes _____ No _____

Please list all prescription medications you will take on trips or activities: _____

Please provide additional information on any boxes checked "Yes" above:

X _____
 Students Signature Date

This information is strictly for the use of the Department of Campus Recreation and may not be released to anyone outside the department without your written consent.