Roanoke College Outdoor Adventures
Medical Information Form

Part I: General Information

Name: _____ Gender: _____

Address: _____ City, State, Zip Code: _____

Date of Birth: _____ Height: _____ Weight: _____

Email Address: _____ Phone Number_____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Family Physician

Name: _____ Phone Number: _____

Health Insurance

Name: _____ Phone Number: _____

Policy Number: _____

Part II: Past and Present Medical Problems/History

A. Conditions or Symptoms	Yes	No		Yes	No		Yes	No
1. Asthma/Respiratory Problems	☐	☐	11. Reproductive Disorders	☐	☐	21. Leg/Hip Problem	☐	☐
2. Gastrointestinal Disturbances	☐	☐	12. Severe Menstrual Cramps	☐	☐	22. Foot Problem	☐	☐
3. Motion Sickness	☐	☐	13. Currently Pregnant	☐	☐	23. Special Diet	☐	☐
4. Diabetes	☐	☐	14. Vision Impairment	☐	☐	24. Allergies (including food)	☐	☐
5. Hypoglycemia	☐	☐	15. Hearing Impairment	☐	☐	25. Cold Injuries	☐	☐
6. Seizure Disorder/Epilepsy	☐	☐	16. Head Injury	☐	☐	26. Heat Injuries	☐	☐
7. Seizure within Past Year	☐	☐	17. Broken Bones	☐	☐	27. Recent Surgery (last 5 years)	☐	☐
8. Dizziness/Fainting Episodes	☐	☐	18. Neck Problem	☐	☐	28. Require Regular Medication	☐	☐
9. Hypoglycemia	☐	☐	19. Back Problem	☐	☐	29. Other (please describe below)	☐	☐
10. Migraines	☐	☐	20. Elbow/Wrist/Hand Problem	☐	☐			

B. Have You Ever Been Treated for the Following?	Yes	No		Yes	No
31. Anxiety	☐	☐	34. ADD/ADHD	☐	☐
32. Depression	☐	☐	35. Bipolar Disorder	☐	☐
33. Substance Abuse/Chemical Dependency	☐	☐	36. Other (please describe below)	☐	☐
34. Eating Disorder	☐	☐			

C. Cardiac Risk Factors	Yes	No		Yes	No
37. Squeezing/Tightness in Chest during Exercise	☐	☐	41. Tobacco Use in Any Form	☐	☐
38. High Blood Pressure/Medication	☐	☐	42. Male over 45 Years of Age	☐	☐
39. Exercise Less than once per week	☐	☐	43. Female over 55 Years of Age	☐	☐
40. Family History Heart Disease/Problems	☐	☐			

This form is confidential and is used only by staff for screening, to treat injury and illness, and to make your trip a positive experience.

If you answered "Yes" to any of the items on the previous page, please explain below. Include the following:

- Specific symptoms
- Date of last occurrence
- How you care for symptom/condition
- Medications you are taking, including purpose, dosage, and frequency
- How often symptoms/condition occurs
- How long symptoms/condition lasts
- How symptom/condition restricts your activity in any way

Item #	Detailed Description

D. Other Considerations

What other medical, behavioral, or psychological factors should we know about you before you start this program?

_____

_____

_____

_____

_____

_____

_____ _____

Participant Signature Date Signed

At least one parent (or guardian) must sign below if the participant is a minor.

_____ _____

Parent/Guardian Signature Date Signed

_____ _____

Reviewed By Date

This form is confidential and is used only by staff for screening, to treat injury and illness, and to make your trip a positive experience.