CONFIDENTIAL

UNIVERSITY of WASHINGTON BOTHELL

University of Washington Bothell
Outdoor Wellness
Participant Information Form

_____ **Participant Name**

_____ **Event Title**

(_____) _____ **Phone**

_____ **Student ID (if applicable)**

University of Washington Outdoor Wellness programs may operate in remote areas where evacuation to modern medical facilities may take hours or even days. There is a detailed course description for every course found here: https://myarc.uwb.edu

Current Health Status: Please indicate if you have or have had any medical conditions that might limit or interfere with your participation during this trip or clinic. If you are unsure about your health and physical conditioning for this trip/clinic, please ask for clarification for the trip activities and then check with your physician.

1. Hearing or vision Problem (including wearing glasses/contacts)	YES	NO	**7.** Heart Problems or High Blood Pressure	YES	NO
2. Respiratory Problems	YES	NO	**8.** Intolerance to High or Low Temperatures	YES	NO
3. Back Problems	YES	NO	**9.** Diabetes/Hypoglycemia	YES	NO
4. Joint Problems (i.e. knees, ankles, shoulders, etc)	YES	NO	**10.** Seizure Disorders	YES	NO
5. Serious Illness or Hospitalizations in the last year	YES	NO	**11.** Anemia, Bleeding Tendencies, or Traits	YES	NO
6. Surgeries in the last month	YES	NO	**12.** Other	YES	NO

Item #	If you have answered "YES" to any of the above items please explain below. How do symptoms/conditions restrict your activity, including your ability to run, lift, climb or perform outdoor activities?

Allergies: Please indicate all allergies (food, medical, insect, latex, etc), your allergic reactions, and medications required.

Allergy	Reaction(s)	Medication Required

Dietary Specifications: Vegetarian Vegan Gluten Free Lactose Free Other:_____

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Medications: Please indicate all medications, prescribed or not, you currently take. Please include all vitamins, supplements, or any other substances used for medicinal purposes.

Medication	Needed for what condition?	Needed during trip?

Swimming ability: Non-Swimmer Recreational Swimmer Competitive Swimmer

Do you have any additional information you would like to share? Please share with us if you have needs or preference for single gender or mixed gender lodging, questions or concerns you would like addressed by staff before departing for this trip, or information about you that you would like to share with your trip leaders.

_____
_____
_____
_____
_____

Doctor's Name:_____ **Phone Number:_____**

Insurance:_____ **Policy Number:_____**

Emergency Contact:_____ **Relationship:_____**

Emergency Contact Phone Number/s: _____

The information above is correct and accurately reflects my current health status. I understand the information on this form will be shared on a "need to know" basis with University of Washington Bothell staff and emergency services personnel. I give permission to photocopy this form.

Name:_____Signature:_____Date:_____

<u>Signature of Parent/Legal Guardian Consent and Release on Behalf of Minor (if participant is under 18):</u>

I am the parent or legal guardian of the above named minor. The information above is correct and accurately reflects the current health status of the above named minor. I understand the information on this form will be shared on a "need to know" basis with University of Washington Bothell staff and emergency services personnel. I give permission to photocopy this form.

Name: _____ Signature: _____
(Please Print)

Phone: _____ Date: _____