CONFIDENTIAL

UW Bothell and Cascadia College
Outdoor Wellness Participant Health Form

CONFIDENTIAL

Information Requested in this form is vital for Outdoor Wellness Leaders to effectively respond if a medical emergency occurs while you are participating in Outdoor Wellness Programs. **All parts of this document must be filled out completely.**

I – General Participant Information

Participant Name (full name):_____
Date of Birth:_____/_____/_____ **Age:**_____ **Gender Identity** _____
Address: _____ **City:**_____ **State:**_____ **Zip:**_____
Phone 1: (_____**)**_____ **(**Cell / Home / Work**)** **Phone 2: (**_____**)**_____ **(**Cell / Home / Work**)**
Email Address: _____
Emergency Contact Name:_____**Relationship to participant:** _____
Address: _____ **City:**_____ **State:**_____ **Zip:**_____
Phone 1: (_____**)**_____ **(**Cell / Home / Work**)** **Phone 2: (**_____**)**_____ **(**Cell / Home / Work**)**
Email Address: _____
Physician Name: _____ **Office Phone: (**_____**)**_____
Medical Insurance Company _____ **Phone: (**_____**)**_____
Policy Number: _____**Name of Policy Holder:** _____

II – Medical Information

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

☐ No Allergies **OR** List Below

Allergy	Reaction(s)	Medication Required

Medications: Please indicate all medications you currently take.

☐ No Medications **OR** List Below

Medication Name	Condition	Dosage (amount & frequency)	Side Effects

Current Physical Activity: Please describe your current exercise regimen (activity type, frequency, duration, strenuousness, etc.)

Current & Historical Health Concerns: Please indicate if you have or have had any medical conditions that might limit or interfere with your participation during this trip or clinic.

1. Hearing or vision Problem (including wearing glasses/contacts)	YES	NO	**9.** Diabetes/Hypoglycemia	YES	NO
2. Respiratory Problems (including asthma, COPD, etc.)	YES	NO	**10.** Seizure Disorders (Please indicate when your last seizure was below)	YES	NO
3. Back Problems	YES	NO	**11.** Anemia, Bleeding Tendencies, or Traits	YES	NO
4. Joint Problems (i.e. knees, ankles, shoulders, etc)	YES	NO	**12.** History of alcohol or drug abuse	YES	NO
5. Serious Illness or Hospitalizations in the last 2 years	YES	NO	**13.** Syncope (fainting)/Dizziness	YES	NO
6. Surgeries in the last year	YES	NO	**14**. Clinically diagnosed Claustrophobia, acrophobia, agoraphobia, depression, schizophrenia, bi-polar, or other mental illness	YES	NO
7. Heart Problems or High Blood Pressure	YES	NO	**15**. Medical Equipment (ex. Canes, insulin pump, etc.)	YES	NO
8. Intolerance to High or Low Temperatures	YES	NO	**16.** Other medical concerns/accommodations	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?

Height (Feet, Inches) _____ Weight (lbs) _____
Have you been to counseling with a psychiatrist/psychologist/therapist within the last 2 years? YES / NO
IF YES, Therapist Name _____
Phone: (_____)_____Address: _____
City _____ State _____ Zip _____
Swimming Ability: Non-Swimmer Fair Good Very Good

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 (print) :_____Signature:_____Date:_____

Parent/Legal Guardian Signature (if participant is under 18):

I am the parent or legal guardian of the above named minor. I contest that the information above is correct and accurately reflects their 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 (print) :_____Signature:_____Date:_____