

YOUTH MEDICAL FORM

OUTDOOR ADVENTURES, UC DAVIS

Trip/Class: _____ Date(s): _____

Participant Name: _____ Age: _____ Gender: _____

Address: _____

Phone: _____ Insurance Carrier / # _____

Please circle YES or NO to each question listed below. Every question must be answered before attending the trip/class. A "Yes" answer does not automatically disqualify participants from attending the trip/class. The information is simply to provide the guide(s) and Outdoor Adventures an assessment of each participant's medical history before heading into the field. This information will remain confidential.

1. Respiratory problems? Asthma? If yes, do you carry an inhaler?	YES NO YES NO	2. Neurological problems? Epilepsy? Migraines?	YES NO
3. Diabetes? If yes, do you use insulin and how often?	YES NO YES NO	4. Cardiac problems? If yes, please list in space provided.	YES NO
5. Knee, hip, ankle, shoulder, arm, or back injuries/operations? If yes, please circle body part and list date of injury.	YES NO	6. Any allergies? If yes, please specify.	YES NO
7. Allergic to insect bites or bee stings? If yes, do you carry an epinephrine pen?	YES NO YES NO	8. Food allergies? Dietary restrictions? Vegan? Vegetarian? If yes, please specify.	YES NO
9. Allergic to any medications? If yes, please list medication and symptoms in adjacent box.	YES NO	List medications and symptoms here.	

10. Currently taking any medications? YES NO If yes, please specify.			REQUIRED FOR SAFETY EQUIPMENT
Medication	Dosage (amt./freq.)	Side Effects/Restrictions	
			Height: _____
			Weight: _____

11. Swimming ability (if applicable): _____ Non-swimmer ___ Recreational _____ Competitive


12. Date of last tetanus inoculation: _____

13. Please list any medical or physical problems that are not covered in the above listed questions that may effect your participation in this trip/class. **Write N/A if it is not applicable.**

EMERGENCY CONTACT INFORMATION

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Phone: () _____	Phone: () _____
Alt. Phone: () _____	Alt. Phone: () _____

I, the parent/guardian of the child listed above, give permission for any adult employee of the Memorial Union Programs & Campus Recreation Department into whose care said minor child has been entrusted to seek emergency medical care for my child at a nearby hospital or medical facility, in the event of illness or injury. I, the parent/guardian, will assume any and all financial responsibility for such emergency medical treatment.

 _____ Parent/Guardian's Printed Name _____ Parent/Guardian's Signature _____ Date