OUTDOOR EXCURSIONS
UNIVERSITY OF CALIFORNIA RIVERSIDE

Confidential Health Information

Complete and return this form as soon as possible in order to allow us time for review and possible follow-up.

General Information

Program Name: _____ **Program Start Date**: _____

Participant Name: _____ **Today's Date:** _____

Height: _____ft._____in. **Weight:** _____lbs **Shoe Size:** _____ **Sex:** Male /Female/Transgender

Address: _____ **City:** _____ **State:** _____

Phone Number: _____ **Email:**_____

Emergency Contact

Name: _____ **Relationship:** _____

Daytime Telephone # :_____ **Evening Telephone #:**_____

Cell phone #:_____

Insurance Information

Each participant is responsible for any medical expenses and should be covered by his/her own illness and accident insurance.

Do you have insurance? **Yes** ☐ **No** ☐

Insurance Company: _____ **Policy/Certificate #** _____

Telephone #: _____

Swimming Ability

Non-Swimmer ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Very Good** ☐

Medical Information

Allergies (including allergies to medicines, foods, insect bites/stings) **None** ☐

Allergy	Reaction	Medication Required (if any)

Continued on back

Current Medications (including psychiatric medication, over-the counter medication, inhalers) **None** ☐

Medication	Taken For: (Symptom/Condition)	Dosage	Date Started	Current Side Effects

Health Profile (We recommend that you consult your physician if you have any questions about whether or not you should participate in an Outdoor Excursion. Answering yes to any of these questions does not constitute an automatic dismissal, though some conditions may require a physician's approval.)

#	**Please √ yes or no– if yes, please describe below**	**Y**	**N**	#	**Please √ yes or no– if yes, please describe below**	**Y**	**N**
1	Seizure within the past 1 year			6	Diabetes (if yes, please explain how it is controlled)		
2	Hospitalization/Emergency Room/Urgent Care visit within the past 1 year			7	Current neck/back/shoulder/knee/ankle/or other joint problems		
3	Asthma (if yes, please bring inhaler)			8	Currently pregnant		
4	Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, or exertional dizziness or faint spells			9	Currently under a doctor's care for any condition		
5	Other cardiac conditions, e.g. heart murmur or rhythm abnormality			10	Other medical issues/illnesses/symptoms/ requirements		
# Describe							
# Describe							

Cardiovascular Risk Factors (Please √ yes or no)

Yes	No	Condition
		Diagnosed high blood pressure, even if being controlled by medication
		Smoker
		Diabetic requiring medication
		Known abnormally high cholesterol level or on a diet or medication for a lipid abnormality
		Family history (parent/sibling) of heart attack, coronary artery by-pass/angioplasty, or sudden, unexplained death **before age 55**
		Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats/exertional dizziness/faint spells

Signature

I certify that all statements on this form are true and complete to the best of my knowledge. I understand that failure to disclose information could result in serious harm to me or other participants.

Participant's Signature _____ Date _____