**Outdoor Adventure**
Student Recreation and Wellness Services
University of Akron

# Health History

Please Print

| Name: | Date: |
|---|---|
| Outing Name: | |

This trip involves participation in activities which are, by nature, physically demanding, and often times take place remote in locations without the opportunity for immediate medical attention. As a participant of an Outdoor Adventure Trip we require full disclosure of your current health. The information you provide is essential, as it may assist with your care in the event of an accident. Full and accurate completion of all sections is very important. The provided information will be kept confidential between the trip leader(s), and health care professionals in the event of an accident. This form is not used to evaluate your ability to participate in any activities. Only qualified health care professionals can make that decision.

| Gender: M F | Age: | Height: | Weight: lbs |
|---|---|---|---|
| Address: | | Phone<br>Cell:<br>Work:<br>Other: | |
| **Emergency Contact Information** | | | |
| Name: | | Relationship: | |
| Address: | | Phone<br>Cell:<br>Work:<br>Other: | |
| Family Physician: | | Phone: | |
| **Medical Insurance Information**<br>*Each participant is strongly encouraged to be covered by his/his own health insurance. The University of Akron, Recreation and Wellness Services, and Outdoor Adventure Services do not provide sickness, health, or accident insurance* | | | |
| Insurance Provider: | | Policy/Group #: | |

Do you have any physical disabilities or conditions that might limit your participation? ☐Yes ☐No
If yes please describe. ___________________________________________

Are you currently under treatment for any illness or medical condition? ☐Yes ☐No
If yes please describe. ___________________________________________

Do you regularly take or need to carry medications? ☐Yes ☐No
If yes please list and describe. ___________________________________________

Do you have any allergies? ☐Yes ☐No If yes please list and describe. ___________________________

Are you allergic to bee or insect stings? ☐Yes ☐No If yes please describe your allergic reaction. ________________

*If you require medications for allergic reactions please bring two doses with you and alert your instructor(s).*

Have you had a cold injury? ☐Yes ☐No Have you had a heat injury (i.e. exhaustion)? ☐Yes ☐No
If yes please describe. ___________________________________________

Do you have a history of heart problems? ☐Yes ☐No If yes, please explain. ___________________________

Have you every undergone surgery within the past year? ☐Yes ☐No . Do you have any open wounds? ☐Yes ☐No
If yes, please explain. ___________________________________________

Do you have any dietary restrictions (gluten, dairy, vegetarian, etc.)? ☐Yes ☐No Please list. ________________

Do you smoke? ☐Yes ☐No Do you wear glasses/contacts? ☐Yes ☐No Do you have dentures/false teeth? ☐Yes ☐No

Can you swim? ☐Yes ☐No Are you First Aid/CPR certified? ☐Yes ☐No exp. _________________