

Glendale Outdoor Leadership School

Health History Form: Activities and Events

Name _____
Last First Middle

Home address _____
Street address City State Zip

Gender: Male _____ Female _____ Birth date ____/____/____ Age _____

Custodial parent/guardian _____
Name

Home address (if different from above) _____
Street address City State Zip

Home phone () _____ Work phone () _____ Cell phone () _____

Second parent or emergency contact _____

Home address _____
Street address City State Zip

Home phone () _____ Work phone () _____ Cell phone () _____

Relationship _____

Emergency Contact (Please list 2 other contacts if the above Persons are not available)

Name _____ Phone # _____

Name _____ Phone # _____

Insurance Information: Is the participant covered by family/hospital insurance? Yes _____ No _____

If so, indicate carrier or plan name _____ group # _____

Insurance carrier address _____ Phone number _____

Name of physician _____ Phone number _____

Allergies

To medication _____

Seasonal _____ Bee stings _____ Asthma _____ Food _____ Other _____

Current Medications, including dosage _____

Does not eat: Red meat _____ Pork _____ Dairy products _____ Poultry _____ Seafood _____ Eggs _____ Other _____

Medications Being Taken:

Please list **ALL** medications (including over-the-counter or nonprescription drugs) taken routinely. Bring enough medication to last the entire time of this event. Keep it in the original packaging bottle that identifies the prescribing physician (if a prescription drug), the name of the medication, the dosage and the frequency of administration.

____ This person takes NO medication on a routine basis *OR* ____ This person takes medication as follows:

Med #1 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____

Med #2 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____

Med #3 _____ Dosage _____ Specific times taken each day _____ Reason for taking _____

Health History

General Question: (Check "yes" answers and explain below)

Has/does the participant:

Had any recent injury, illness, or infectious disease?	_____	Ever had back problems?	_____
Have a chronic or recurring illness/condition?	_____	Ever had problems with joints (e.g. knees, ankles)?	_____
Ever been hospitalized?	_____	Have an orthodontic appliance being brought to the event?	_____
Ever had surgery?	_____	Have any skin problems	_____
Have frequent headaches?	_____	Have diabetes?	_____
Ever had a head injury?	_____	Have asthma?	_____
Ever been knocked unconscious?	_____	Ever had an eating disorder?	_____
Wear glasses, contacts, or protective eye wear?	_____	Had a problem with diarrhea/constipation?	_____
Ever passed out during or after exercise?	_____	Ever had seizures?	_____
Ever been dizzy during or after exercise?	_____	Ever had high blood pressure?	_____
Ever had chest pain during or after exercise?	_____	Ever been diagnosed with a heart murmur?	_____
		Other?	_____

Please explain any **yes** answers.

Use this space to provide **any** additional information about the participant's behavioral, physical, emotional, or mental health.

Describe your current fitness and physical activity levels.

I certify that the above information is complete and accurate to the best of my knowledge. I hereby state that

_____ is capable of safely participating in activities offered through Glendale
Name of Participant

Outdoor Leadership School. I understand that there is inherent risk with participation; including serious

injury and/or death. If any of the above stated information changes, I will inform GOLS.

Print name

Signature (participant or guardian)

Date