

Medical Health History Form



The Environmental Institute (EI) collects medical information in order to provide a safer, more successful experience for all participants. We rely on the information you provide to educate EI as to the applicant's preparedness to participate. EI requires you (parents/guardians for minors) to complete the Medical Health History Form. EI staff will review medical form and contact you (parents/guardians for minors) if questions arise. EI treats all medical information with confidentiality, and shares pertinent information with EI staff on a need-to-know basis.

If you have any questions or concerns regarding forms, please call 970-248-2129.

Participant name: _____ Age: _____ Birth date: _____

City, State: _____ Gender: M F Weight: _____

In case of Emergency, contact:

Name: _____ Home Phone: _____

Relationship: _____ Business Phone: _____

ALLERGIES

Please list all allergies to **Medications, Foods, or Environment** (insect stings, etc.). Attach additional sheets if needed. **If your student carries epinephrine we will need a copy of their Anaphylaxis Care Form.**

Allergy	Date of Last Reaction	Description of Reaction	Treatment	Epinephrine prescription
				Yes / No
				Yes / No

MEDICATIONS

Does your student take any medications (Prescription or OTC) that **they will be bringing on this trip? If your student carries an albuterol inhaler, we will need a copy of their Asthma Care Form.**

I take NO medications. I take medication(s) as follows (attach additional pages for more medications):

Medication Name	Dosage	Purpose for taking	Side Effects	

MEDICAL CONDITIONS

We want your student to participate and we strive to accommodate most medical conditions. Please be thorough in the information you provide. **Do you have any medical or mental health conditions that you would like us to be aware of?** No Yes (If Yes, please elaborate below)

CONSENT AND RELEASE

Participant Authorization (Parent or guardian for participants under 18)

The above information is correct and complete to the best of my knowledge. The person herein described has permission to engage in all course activities except as noted. I hereby give permission to EI to provide routine health care, dispense prescribed medications, and seek emergency medical treatment including ordering x-rays or routine tests. I agree to the release of any records necessary for insurance purposes. In the event I cannot be reached in an emergency, I hereby give permission to the physician selected by EI to secure and administer treatment, including hospitalization, for the person herein described. This completed form may be photocopied for use out of the office by EI staff.

Signature of Parent/Guardian _____ Date: _____

