HEALTH AND MEDICAL HISTORY AND RELEASE

LOYOLA UNIVERSITY OF CHICAGO OFFICE FOR OUTDOOR EXPERIENTIAL EDUCATION

PARTICIPANT

PLEASE PRINT

This form will be kept confidential. Its purpose is to provide the Office for Outdoor Experiential Education with needed information to adequately care for participants during the PROGRAM and in case of emergency.

NAME:____
(LAST) (FIRST) (MIDDLE)

CAMPUS ADDRESS:____TEL NO.: (____)___________

HOME ADDRESS____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME TEL NO.: (_____)____________

HEIGHT __________ WEIGHT _______ SEX ______ AGE _______

HEALTH/ACCIDENT INSURANCE CARRIER:_______________________TEL : (___)____________

NAME OF POLICY HOLDER: ___________________________ POLICY EXPIRATION DATE: ____________

POLICY NO.: GROUP NO.:

PARTICIPANT'S PHYSICIAN:______________________________________TEL NO: (___)____________

PHYSICIAN'S ADDRESS____
(STREET) (CITY) (STATE) (ZIP CODE)

IN AN EMERGENCY PLEASE NOTIFY:

1. NAME__________________________________RELATIONSHIP:____________________

ADDRESS____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME/CELL NO.:______________________________ WORK NO.:____________________
(AREA CODE) (NUMBER) (AREA CODE) (NUMBER)

2. NAME__________________________________RELATIONSHIP:____________________

ADDRESS____
(STREET) (CITY) (STATE) (ZIP CODE)

HOME/CELL NO.:______________________________ WORK NO.:____________________
(AREA CODE) (NUMBER) (AREA CODE) (NUMBER)

LIST EQUIPMENT NEEDED SUCH AS WHEELCHAIR, BRACES, GLASSES, CONTACT LENS, ETC. (continue on back if needed):

____

____

Please list any chronic or acute medical problems, significant illnesses, medical restrictions, or physical or mental disabilities (past or present) (continue on back if needed):

____

____

Please explain any other information the Office of Outdoor Experiential Education should be aware of while you are on this adventure program trip and **SPECIFY ANY PHYSICAL OR BEHAVIORAL CONDITIONS which may affect or limit your full participation in this program or for which you may require a reasonable accommodation:**

____

____

List all medications currently being taken (prescription or non-prescription): ______________________________

____

ALLERGIES: Food, latex, insects, plants, medications, other ☐ **No** ☐ **Yes** If Yes, please specify and explain reactions.

____

____

Give Dates of Last Inoculation.

_________ **Tetanus Toxoid**

I plan to attend an Outdoor Experiential Education Program, hereinafter referred to as "PROGRAM." I have verified with my health care providers that I have no past or current physical or psychological condition that might affect my participation in the PROGRAM, other than as described on this form. I am able to participate without causing harm to myself or to others. The medical information provided is accurate and all pertinent medical conditions have been disclosed. I fully realize that injury, illness or death could result from or during my participation in the PROGRAM. In case of accident or illness, I give my permission to Loyola to obtain and/or provide medical treatment as deemed appropriate. I will assume responsibility for any costs reasonably associated with medical services.

PARTICIPANT'S SIGNATURE_______________________________DATE _________________

Parental consent for Participants under 18 years of age

And I, the minor's parent and/or legal guardian, certify that I am over 18 years of age, and that the minor participant has my permission to attend a PROGRAM. I have verified with the minor student's heath care providers that I have no past or current physical or psychological condition that might affect the minor participant's participation in the PROGRAM, other than as described on this form. The minor participant is able to participate without causing harm to himself/herself or to others. I fully realize that injury, illness or death could result from or during the minor participant's participation in the PROGRAM. In case of accident or illness, I give my permission to Loyola to obtain and/or provide medical treatment as deemed appropriate. I will assume responsibility for any costs reasonably associated with medical services.

Printed name of Parent/Guardian____

Address____

(street) (city) (State) (zip)

Phone (____)________________ **Date**____/_____/_____

Parent/Guardian signature____