CONFIDENTIAL	**University of Washington Bothell and Cascadia College** **Outdoor Wellness Adventure Trip Participant Health Form**	CONFIDENTIAL

Name:_________________________________ **Date of Birth:**_______________ **Trip:**__________________________

Current Health Status: Please indicate if you have or have had any medical conditions that might limit or interfere with your participation during this trip or clinic. If you are unsure about your health and physical conditioning for this trip/clinic, please ask for clarification for the trip activities and then check with your physician.

1. Hearing or vision Problem (including wearing glasses/contacts)	YES	NO	**7.** Heart Problems or High Blood Pressure	YES	NO
2. Respiratory Problems	YES	NO	**8.** Intolerance to High or Low Temperatures	YES	NO
3. Back Problems	YES	NO	**9.** Diabetes/Hypoglycemia	YES	NO
4. Joint Problems (i.e. knees, ankles, shoulders, etc)	YES	NO	**10.** Seizure Disorders	YES	NO
5. Serious Illness or Hospitalizations in the last year	YES	NO	**11.** Anemia, Bleeding Tendencies, or Traits	YES	NO
6. Surgeries in the last month	YES	NO	**12.** Other	YES	NO

Item #	If you have answered "YES" to any of the above items, please explain below. How do symptoms/conditions restrict your activity, including your ability to run, lift, climb or perform outdoor activities?

Allergies: Please indicate all allergies (food, medical, insect, latex, etc), your allergic reactions, and medications required.

Allergy	Reaction(s)	Medication Required

Medications: Please indicate all medications you currently take.

Medication	Needed for what condition?	Needed during trip?

Swimming Ability: Non-Swimmer Fair Good Very Good

Doctor's Name:____ Phone Number:______________________________

Insurance:____ Policy Number:______________________________

Emergency Contact:_________________________________Phone Number:______________________Relationship:______________

The information above is correct and accurately reflects my current health status. I understand the information on this form will be shared on a "need to know" basis with University of Washington Bothell staff and emergency services personnel. I give permission to photocopy this form.

Name:____**Signature:**_____________________________________**Date:**__________