## **CONFIDENTIAL**

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

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Phone Number:    Phone Number:   Policy Number:   Relationship:	Name:		_ Date o	_ Date of Birth:		Trip:			
glasses/contacts	participation	during this trip o	r clinic. If you are unsu	ure about	your hea		<del>-</del>	-	ask for
3. Back Problems  A. Joint Problems (i.e. knees, ankles, shoulders, etc)  A. Joint Problems (i.e. knees, ankles, shoulders, etc)  S. Serious Illness or Hospitalizations in the last year  YES  NO  10. Seizure Disorders  YES  NO  11. Anemia, Bleeding Tendencies, or Traits  YES  NO  6. Surgeries in the last month  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?  Medication  Needed during trip?  Phone Number:  Phone Number:  Policy Number:  Policy Number:  Policy 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 sermission to photocopy this form.			YES	NO	7. Heart Problems or High Blood Pressure		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 11. Anemia, Bleeding Tendencies, or Traits YES NO 12. Other YES NO 13. Other YES NO 14. Other YES NO 14. Other YES NO 15. Other YES NO 16. Surgeries in the last month YES NO 17. Other YES NO 18. Other YES NO 19. Other YES N	2. Respiratory Problems		YES	NO	8. Intolerance to High or Low Temperatures		YES	NO	
5. Serious Illness or Hospitalizations in the last year  6. Surgeries in the last month  12. Other  13. Other  14. Other  15. NO  15. Other  16. Other  16. Other  17. Other  18. NO  17. Other  18. NO  18. Other  19. NO  19. Other	3. Back Problems		YES	NO	9. Diabetes/Hypoglycemia		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 litems, please explain below. How do symptoms/conditions restrict your activity, including your ability to run, lift, climb or perform outdoor activities?	4. Joint Problems (i.e. knees, ankles, shoulders, etc)		YES	NO	10. Seizure Disorders		YES	NO	
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Including your ability to run, lift, climb or perform outdoor activities?	<b>6.</b> Surgerie	s in the last month		YES	NO	12. Other		YES	NO
Allergy Reaction(s) Medication Required  Wedications: 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: Policy Number: Relationship: 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.	Item #						. How do symptoms/conditions rest	rict your acti	ivity,
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Medication   Needed for what condition?   Needed during trip?    Swimming Ability: Non-Swimmer   Fair   Good   Very Good    Doctor's Name:	_						_		
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 bermission to photocopy this form.	Medication	<b>ns:</b> Please indicat	te all medications yc	ou currer	ntly take.				
Phone Number:    Phone Number:   Policy Number:   Relationship:	Medication	Medication Needed for what con		dition?			Needed during trip?		
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Name: Signature: Date:	oe shared o	n a "need to knov	v" basis with Universi	_					n will
	Name:			Signature:			Date:		