CIWC Medical Form

Please complete this form and return it to your trip leader within 30 days.

Please complete this form as accurately as possible. It is essential for trip leaders to evaluate individual and group health needs as part of trip planning, and for this information to be available during emergencies. The information will remain confidential, and then be destroyed. Should the need arise, this information will be given to the proper medical authorities. Your trip leader will follow-up by phone or email, as necessary.

General Information

Name:_____ Age:_____ Date of Birth_____

Height_____ Weight:_____ Gender:_____ Blood Pressure_____ / _____ Resting Heart Rate:_____ bpm

Blood Type (if known) _____

Address:_____ Email:_____

City:_____ State: IN Zip:_____

Mobile Phone:_____ Home Phone:_____

Primary Emergency Contact:_____ Relationship:_____

Home:_____ Work: _____ Mobile: _____

Secondary Emergency Contact:_____ Relationship:_____

Home:_____ Work: _____ Mobile: _____

Date of last tetanus immunization:_____ Please describe your swimming ability:_____

Date of most recent physical:_____ Physician's name:_____

Address:_____ Phone:_____

Evacuation and Medical Insurance

We strongly encourage you to have medical insurance and to bring your insurance card or other documentation with you on the trip. Evacuation is *not* a CIWC expense, and evacuation insurance can save you the cost of paying for your evacuation should this become necessary.

Medical Insurance	Evacuation Insurance
Company Name:_____	Company Name:_____
Policy Number:_____	Policy Number:_____
Contact Phone Number:_____	Contact Phone Number:_____
	Coverage Amount_____

Allergies

Include allergies to food, insect bites and stings, medicines, animals and environment (dust, pollen, etc.)
Use separate sheet as needed.

Select ☐ **NO ALLERGIES if none**

Allergy	Reaction	Medication Required

Medications

Please list all prescription, over the counter, and natural medications you are currently taking. Note if this is a recent change in dosage or prescription. ***Use separate sheet as needed.***

Medication Name	Dosage	Frequency	Side Effects (known and potential)	Reason for Taking

General Medical History

Please answer the following medical history questions***. If answering YES, use a separate sheet to explain history in more detail.***

Do you currently have, or have a history of, the following conditions:

YES ○ NO ○ _____ Respiratory problems, Asthma, Do you smoke

YES ○ NO ○ _____ Diabetes

YES ○ NO ○ _____ Bone, Joint, Muscle Problems

YES ○ NO ○ _____ Cardiac problems, Hypertension

YES ○ NO ○ _____ Gastrointestinal problems

YES ○ NO ○ _____ Vision or Eye problems

YES ○ NO ○ _____ Hearing problems

YES ○ NO ○ _____ Neurological problems, Seizures

YES ○ NO ○ _____ Head trauma , Traumatic Brain Injury

YES ○ NO ○ _____ Substance Abuse, Anxiety, Depression

YES ○ NO ○ _____ If female, are you pregnant?

YES ○ NO ○ _____ Have you had a recent illness within the last 12 months?

YES ○ NO ○ _____ Have you had surgery or been hospitalized in the last year?

YES ○ NO ○ _____ Have you ever had problems related to exposure to altitude?

YES ○ NO ○ _____ Any other Health complaint or medical issue that would affect your participation on this trip

If yes, Please explain_____.

The information provided here is a complete and accurate statement of any physical and psychological conditions that may affect my participation on this trip. I realize that failure to disclose such information could result in serious harm to myself and other participants. I understand the outing may require vigorous activity that is both physically and mentally demanding in isolated areas without medical facilities. **I am fully capable of participating on this trip. I agree to inform my trip leader should there be any changes to my health status prior to the start of the trip**.

Trip Name_____ **Trip Dates**_____.

Participant Signature_____ **Date**_____.

CIWC Medical Form, Additional Information