St. Lawrence University Outdoor Program
Participant Medical Form

Name:_____ Date of Birth:_____ Sex: M or F Age: _____
School Address: _____
Home Address: _____
School Phone: _____Home Phone: _____

IN CASE OF EMERGENCY CONTACT:
Name: _____ Relation: _____
Home Address: _____ Phone: _____
Business Address: _____ Phone: _____

Health History: Please circle YES or NO for each item and provide details on EVERY "YES" answer in the explanation section.

Do you currently have or have you had a history of:

1.	Knee, ankle, back or any other joint problems including sprains, injuries or operations?	Yes	No
2.	Respiratory problems including asthma?	Yes	No
3.	Gastrointestinal disturbances?	Yes	No
4.	Eating disorders including anorexia and/or bulimia?	Yes	No
5.	Disorders of the urinary tract?	Yes	No
6.	Hypertension?	Yes	No
7.	Liver dysfunction?	Yes	No
8.	Arthritis?	Yes	No
9.	Neurological problems?	Yes	No
10.	Bleeding or Clotting disorders?	Yes	No
11.	Epilepsy, convulsions or seizures?	Yes	No
12.	Diabetes?	Yes	No
13.	Treatment or medication for abdominal cramps? Menstrual cramps?	Yes	No
14.	Psychiatric/psychological treatment or counseling?	Yes	No
15.	Treatment or problems with drug/alcohol/chemical abuse or dependency?	Yes	No
16.	Thyroid problems?	Yes	No
17.	Cardiac problems?	Yes	No
18.	Physical disability?	Yes	No
19.	Learning disability?	Yes	No
20.	Had frostbite? Describe symptoms and treatment	Yes	No
21.	Any other diseases?	Yes	No
22.	Any operations or serious injuries?	Yes	No
23.	Allergy to any medications? Please be specific	Yes	No
24.	Allergy to foods, insects, plants, etc? Please specify	Yes	No
25.	Currently taking medication? Please specify dose	Yes	No
26.	Currently on a medically prescribed diet?	Yes	No
27.	Is there any additional information we would want to know?	Yes	No

Explanation of all "Yes" answers --- Please be specific. Add additional paper if needed.

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IMPORTANT: THIS BOX MUST BE COMPLETED FOR ATTENDANCE
This health history is correct so far as I know. I hereby give permission to the medical personnel selected by the Guide or Trip Leader to order X-rays, routine tests, and treatment for me. In the event the person to be notified in case of emergency cannot be reached in an emergency, I hereby give permission to the physician selected by the Guide or Trip Leader to hospitalize, secure proper treatment for me, and to order injection and/or anesthesia and/or surgery for me. This form may be photocopied for use.
Signature: _____ Date: _____