Loyola University Maryland
Department of Recreational Sports

Outdoor Adventure Experience
Health and Medical Record

To assist you in assessing your ability to succeed safely in our programs and to enable us to assist you in case of an emergency, please complete this Health and Medical Record. Please note that the Department of Recreational Sports does not administer medications (unless to children), except in emergencies, and we accept no responsibility for determining an individual's fitness to participate in Outdoor Adventure Experience programs. **Any questions you may have about your ability to participate should be directed to your physician.** The information you are providing in the Health and Medical Record will be treated confidentially. It will not be released to anyone without your permission, except in an emergency situation where you are unable to otherwise communicate your wishes.

GENERAL

Name: _____ _____ ___ Class Year: _____
Last First MI

Loyola ID Number: _____ Faculty/ Staff/ Admin/ Alum: _____

Address: _____ Cell Phone: _____

_____ Date of Birth: ____/____/____

_____ Height: _____ Weight: _____

Sex/ Gender: _____

EMERGENCY CONTACT INFORMATION

Emergency Contact: _____ Relation: _____

Emergency Contact Phone Number: *Day*: _____ *Evening*: _____

Health Insurance Company: _____

Policy Holder: _____ Policy Number: _____ Group Number: _____

MEDICAL HISTORY

Please rate your current frequency of physical activity.

	Never	1-2 times/ week	3-4 times/ week	5 or more times/ week
Walking	○	○	○	○
Jogging	○	○	○	○
Cycling	○	○	○	○
Aerobics	○	○	○	○
General Sports	○	○	○	○

What is your swimming ability? ○ None ○ Beginner ○ Intermediate ○ Advanced

Are you currently pregnant? ○ Yes ○ No

Are you a smoker? ○ Yes ○ No

MEDICAL HISTORY, cont.

Have you ever experienced an **anaphylaxis reaction**? ○ Yes ○ No

Do you have **allergies**? ○ Yes ○ No Do you carry personal medications? ○ Yes ○ No

Allergy	*Reaction*	*Treatment*

Do you have **diabetes**? ○ Yes ○ No Do you carry personal medications? ○ Yes ○ No

Type of diabetes	*Reaction*	*Treatment*

Do you have **asthma**? ○ Yes ○ No Do you carry personal medications? ○ Yes ○ No

Type of asthma	*Reaction*	*Treatment*

Have you ever experienced **seizures**? ○ Yes ○ No Do you carry personal medications? ○ Yes ○ No

Type of seizures	*Reaction*	*Treatment*

Have you ever had **cardiac symptoms**? ○ Yes ○ No Do you carry personal medications? ○ Yes ○ No

Cardiac symptoms	*Reaction*	*Treatment*

Pre-existing condition information.

*Please rate each as: **C** (current within last 12 months), **P** (past), or **N/A***			
Complete/ partial hearing loss		History of heart disease (in family)	
Head injury		Palpitations (heart)	
Heat related illness		Heart murmur	
Orthopedic injury		Chest pains with or without exercise	
Dizzy or faint during exercise		Bleeding disorder	
Shortness of breath with or without exercise		Stroke	
Ever told not to participate in sports?		High blood pressure	

If marked **C** (current) or **P** (past), please provide additional information.

_____
_____
_____
_____

Please list any additional illnesses or medical conditions for which you are currently being treated.

Condition	*Year Diagnosed*	*Treatment/ Medication*
Condition	*Year Diagnosed*	*Treatment/ Medication*

Please list any operations or hospitalizations you have had in the past year.

Reason	*Hospital*	*Doctor*	*Date*
Reason	*Hospital*	*Doctor*	*Date*

Please list additional medications you are now taking.

Name of Medication	*Dose*	*Frequency of Dose*
Name of Medication	*Dose*	*Frequency of Dose*
Name of Medication	*Dose*	*Frequency of Dose*
Name of Medication	*Dose*	*Frequency of Dose*

PHYSICIAN CONSULTATION

If you responded affirmatively to any of our requests for medical information, we urge you to contact your physician to discuss your ability to participate in Outdoor Adventure Experience programs. If you or your physician requires additional information regarding these activities, please contact our office.

I have consulted with my physician about my participation in the Outdoor Adventure Experience program.

◯ Yes ◯ No

If you answered, "Yes", to the previous question, please provide the physicians recommendation:

◯ Advised to participate

◯ Advised not to participate

◯ Advised to use caution while participating in certain activities

Any additional comments?

_____

_____

_____

_____

_____

The foregoing information is true and correct to the best of my knowledge.

_____ _____
Signature *Date*

PARENTAL CONSENT (To be completed by parents or guardians of students under the age of 18.)

The laws of Maryland require that surgical and medical treatment of minors and release of medical information to hospitals, other physicians, and insurance companies about conditions treated by us be at the request of and with the approval of their parents. This right to request and approval may be delegated to University officials. Although it is our policy to notify the parents as soon as possible in the event of major illness or injury, it is impractical to notify for every minor illness or injury requiring treatment. It will help us protect the health of your child if you would delegate to us discretion in these matters.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my child and agree to present information concerning their medical condition to other responsible authorities when deemed desirable. No major operations will be performed, except in extreme emergency, without parents being fully informed.

_____ _____
Signature of Parent or Legal Guardian *Date*

_____ _____
Signature of Student *Date*

Please return this form as soon as possible to allow time for review. It is possible that further medical evaluation is needed to approve your participation in some OAE activities.

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Outdoor Adventures

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