Health and Medical Record for Freshman Outdoor Orientation Trips (FOOT)

Instructions.

1. ONLY THOSE STUDENTS WHO FILE THIS RECORD PROPERLY CAN PARTICIPATE IN FOOT.
2. The pre-participation physical exam (Part C) MUST be completed by certified and licensed physicians (MD, DO), nurse practitioners, or physician assistants. Informed consent, release agreement, and authorization (Part B) MUST be given by both the participant AND by their parent or guardian.
3. ALL parts of this form, A, B, and C, are DUE JULY 15.
4. By that date, the COMPLETE and SIGNED record must be SCANNED and saved in PORTABLE DOCUMENT FORMAT (PDF). That ONE PDF FILE must be RENAMED "LAST NAME, FIRST NAME.PDF," and E-MAILED to footsummercoordinators@gmail.com.
5. Participants MUST BRING a SECOND COPY of their record WITH THEM TO CAMPUS.
6. This is NOT the Yale Health Form. It should NOT be sent to Yale Health. We do recommend completing the Yale Health Form and Physical Exam at the same time, for convenience, but that form should be sent to Yale Health, and NOT to FOOT.

Questions? E-mail footsummercoordinators@gmail.com.

Part A: General Information & Health History. Print CLEARY & LEGIBLY!!

Full name_____ Date of birth_____
Street address_____ City_____ State or province _____ ZIP_____
Phone (day)_____ (night)_____

E-mail address_____

In case of emergency, notify the persons below:
Name_____ Relationship_____
Address_____ Phone (day)_____ (night)_____
Alternate contact name_____ Phone (day)_____ (night)_____

Physician name_____ Phone_____

Health insurance. The Yale Health Plan will covers participants who have not waived the plan. Students who waived the Yale Health Plan must be covered by their own health insurance during FOOT to participate in a trip.

Do you plan to use the Yale Health Plan? Circle one: Yes No

If you ARE PLANNING TO WAIVE the Yale Health Plan, provide the following information:
Name of health insurance provider_____
Policy number_____ Expiration date_____

Health & fitness. Describe ANY dietary restrictions you observe for health, religious, or other reasons, including any food allergies. Be thorough. If you keep kosher, specify how. _____

_____

How well can you swim? Circle one: Not at all Barely Comfortably

Part B: Informed Consent, Release Agreement, and Authorization.

I understand that there are inherent risks in a trip of this nature. I will be living in the out-of-doors and will be exposed to weather conditions and rough terrain. I acknowledge that at times I will be remote from any medical facilities. I understand that at times accidents and injuries may occur in such conditions, and that not all of them can be prevented or avoided. I waive any claim against FOOT, Yale or individuals involved in the program for any injury I suffer due to my own negligence, even if FOOT, Yale or other parties were also negligent.

I also understand that I must be in satisfactory physical condition in order to participate safely in this trip. I give permission to FOOT and the FOOT Leaders to review the information about my health and medical condition that I have provided to FOOT and the University Health Services. I understand that if I arrive at Yale in a condition other than the one stated in the medical reports, FOOT has the right to refuse to allow me to participate in the trip. If FOOT nevertheless does allow me to participate, I waive any claim against FOOT, Yale and any individuals involved in the program for any resulting illness or injury I may suffer.

In the event of an emergency in which I require medical care, I give permission to the physician treating me to order injection, anesthesia or surgery. I understand that reasonable attempts will be made to reach my parents for such permission.

I certify that I have read and agree to all of the above. Participant's signature_____ Date_____

I certify that I am the parent or guardian of the student who signed above, and that I have read and agree to all of the above.

Parent or guardian's signature_____ Date_____ Printed name_____

Part C: Pre-Participation Physical. To be completed by the participant's **Healthcare Provider**.

Participant's full name:_____ Date of birth:_____

! You are being asked to certify that this individual has no contraindication for participation in a four- or six-day backpacking trip.

Please provide the following information.

Height (inches)_____ Weight (lbs)_____ BMI_____ Blood pressure_____/_____ Pulse_____

Please list any allergies, especially those to FOODS, INSECT BITES/STINGS, PLANTS, or MEDICATIONS, including PENICILLIN. Be specific, listing any medications used for their treatment. _____
_____
_____
_____
Participants with EpiPens should bring them. Participants allergic to bee stings should bring a bee sting kit.

Is the participant taking any medication regularly? Circle one: Yes No

If yes, please list all regular medications and their purpose: _____
_____
_____
_____

Date of last tetanus shot: _____

Does the student have any physical handicaps? Problems with hearing or vision? Psychiatric disorders? Respiratory ailments? Asthma? Diabetes? Bad knees? Bad ankles? Reactions to temperature extremes? Muscle cramps? Seizures? High or low blood pressure? Heart disease? Hypertension? Fears of heights or confined places? _____
_____
_____
_____

Describe any recent illnesses, injuries, hospitalizations or surgeries: _____
_____
_____

On the basis of your knowledge of the participant's medical history and this examination, do you advise any limitations on their participation in strenuous physical activity, such as backpacking for four to six days? Students in the program will be traveling under their own power, often carrying loads of up to fifty pounds, on their backs, seven miles in a day. We need to know if, in your opinion, there is anything in the participant's medical background that should preclude or limit his or her participation. Please be as specific as necessary in noting the problem and the limitations it might impose. Remember that the safety of the entire group depends on the good condition of each member.

Comment: _____
_____
_____
_____
_____

Examiner's signature: _____ Date: _____ Printed name: _____
Address: _____ City: _____ State or province ____ ZIP: _____

Office phone: _____