

# Educate Wild! Medical History Template

## PROGRAM NAME

*This Document Has Legal Consequences. It Must Be Completed And Signed Prior To Participation.  
Please Read It Carefully Before Signing.*

(Please Print)

Participant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_

### Emergency Contact Information

Emergency Contact #1 Name: \_\_\_\_\_

Address (town, state): \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Does this person speak and read English? Yes / Some / No

If no, what is their primary language? \_\_\_\_\_

If not, who can facilitate communication with this person in the event that you are not able to do so?

\_\_\_\_\_

Emergency Contact #2 Name: \_\_\_\_\_

Address (town, state): \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Does this person speak and read English? Yes / Some / No

If no, what is their primary language? \_\_\_\_\_

If not, who can facilitate communication with this person in the event that you are not able to do so?

\_\_\_\_\_

**Program Name Student Medical Information  
(Confidential)**

(Please Print)

**Participant's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Email:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Primary Physician Information**

**Primary Physician or Clinic:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Insurance Company:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group #:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

Please indicate any and all special medical conditions NAU may need to know including any surgeries, injuries or illnesses in the last two years. Be sure to list anything that required hospitalization.

Date	What happened?	Treatment	Current Status

- Swimming ability:       Non-swimmer    Recreational       Competitive
- Have you ever been camping?       Yes       No
- Have you ever visited the mountains?       Yes       No
- If so, did the elevation bother you?       Yes       No

List any and all medication(s) taken on a regular basis for any reason, including medication taken for illness(es), allergies, medical prescriptions, vitamins, recent injuries or etc.; use additional paper if necessary, and please attach a copy of the prescription to this document.

Medication	Frequency	Purpose

Dietary Preference:       Vegan       Vegetarian       Other (explain below)

Please note that we will accommodate food allergies, but not always be able to make accommodations for dietary preferences and food sensitivities.

Please list allergies to medications, foods, or other items (food, pets, etc.).

If you have allergies, have you ever needed hospitalization for an allergy attack?    Yes    No

Allergy	What happens?	Last Occurrence	Treatment
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### Medical Information Release

I authorize the **Program Name** (hereafter the Program) staff to obtain or provide emergency hospitalization, surgical, or other medical care for me. I understand that situations may arise in which third-party medical care is not available and which will require the staff to provide first aid and possibly more advanced procedures, employing wilderness first responder training. All medical information will be kept confidential except that information may be disclosed to any medical or other provider as needed for my care. If the Program arranges treatment for me by a medical provider, I authorize that medical provider to release information about me and my condition and treatment to the Program. Costs reasonably associated with medical services, including evacuation, shall be borne by me.

Students with a variety of medical and psychological difficulties have participated in the Program in the past. However, the Program must be aware of these conditions. (Failure to disclose such information could result in serious harm to you and to fellow students.) I understand that I may be in remote areas, several hours or days away from any medical facility or where communication, transportation, or evacuation is subject to delay. If I arrive at the course start with a pre-existing medical, behavioral, or psychological condition, which is not indicated on my medical form, I understand that I may have to leave the course and be charged an evacuation fee.

Printed Name

Student (or Legal Guardian) Signature

Date