

# MEDICAL/RELEASE FORM 2010

Please note that all individuals must submit an updated, original signed copy of this form for each program season before participating in an OE program. You only have to submit this form once—no matter how many OE trips you plan to sign up for—unless there has been a significant change in your health status. If so, please resubmit this form.

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email \_\_\_\_\_

Primary Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Male  Female



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## EMERGENCY INFORMATION

Emergency Contact Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Health Insurance Provider \_\_\_\_\_ Policy/ID number \_\_\_\_\_

Primary physician name \_\_\_\_\_ Phone \_\_\_\_\_

## GENERAL QUESTIONS

My general physical condition is (1 = poor physical condition, 5 = excellent physical condition) . . . . .  1  2  3  4  5

Are you nervous in the outdoors? . . . . .  Yes  No

Can you make your needs known during a program? . . . . .  Yes  No

Can you follow multi-step instructions? . . . . .  Yes  No

Are you nervous in or around water? . . . . .  Yes  No

Can you swim? . . . . .  Yes  No

Are you independent with activities of daily living (e.g. bathing, eating, bathroom, dressing?) . . . . .  Yes  No

Will you be able to refrain from behaviors that pose a risk to yourself and/or others? . . . . .  Yes  No

Will you be accompanied by a Personal Care Assistant? . . . . .  Yes  No

If yes, what is his/her name? \_\_\_\_\_ Note: PCA's need to fill out a separate Medical/Release form.

## MEDICATIONS

Are you using any medications (prescription or non-prescription)? . . . . .  Yes  No

If yes, list each medication, the related condition, and dosage/frequency

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

Are you able to take these medications independently and without a reminder? . . . . .  Yes  No

## SPECIFIC ACCOMMODATIONS

Do you have any sensory, cognitive, physical, or social/emotional disabilities? . . . . .  Yes  No

If yes, please list \_\_\_\_\_

Will you require any special accommodations in order to participate with OE (sighted guide, ASL interpreter, etc.)? . . . . .  Yes  No

If yes, please list \_\_\_\_\_

Do you use a wheelchair, crutches, or other assistive devices? . . . . .  Yes  No

If yes, please list \_\_\_\_\_

**OVER (please complete both sides) ►**

**ALLERGIES/DIETARY RESTRICTIONS**

Do you have any allergic reactions (to bees, drugs, foods, etc.) or dietary restrictions? . . . . .  Yes  No

If yes, please list \_\_\_\_\_

**MEDICAL INFORMATION & HISTORY**

Do you have, or have you had, any of the following conditions or symptoms:

- |  |  |  |  |
|--|--|--|--|
| Seizure within the past year . . . . .                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Asthma/Shortness of Breath . . . . .   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hospitalization or injuries within past year . . . . . | <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes . . . . .                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Condition . . . . .                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypoglycemia . . . . .                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure . . . . .                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eating Disorders . . . . .             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease/Heart Murmur . . . . .                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Circulation Problems . . . . .         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches . . . . .                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting or Dizziness . . . . .        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Traumatic Brain Injury . . . . .                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Muscle Cramps . . . . .                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Active Hepatitis . . . . .                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Intolerance to heat or cold . . . . .  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding or Blood Disorder . . . . .                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy or seizure disorder . . . . . | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you have checked off "yes" for any of the previous items, please explain below. Include the following:

- What specific symptoms are occurring
- How long symptom/condition last
- Date of last occurrence
- How often symptom/condition occurs
- How you care for symptom/condition
- How symptom/condition restricts you

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**RELEASE OF LIABILITY/ASSUMPTION OF RISK**

**Please read each of the following statements and sign as indicated below.**

**If you are under 18 or if you have a legal guardian, your parent or guardian must sign.**

In consideration of the services of Outdoor Explorations, Inc., its officers, directors, agents, employees, volunteers and leaders, and all other persons or entities associated with it (collectively, OE), receipt of which is hereby acknowledged, I and any parent or guardian signing below, for ourselves, our heirs, survivors, administrators, successors, accomplices, and assigns (collectively, I), acknowledge and knowingly and voluntarily agree as follows: I acknowledge that the outdoor activities in which OE participates—including, but not limited to, canoeing, kayaking, swimming, snowshoeing, backpacking, ice skating, camping, challenge activities, whitewater rafting, hiking, ropes, sailing, rock climbing, trail maintenance, and environmental service work—involve certain risks which may cause damage to or loss of my equipment, injury, illness or, in extreme cases, permanent trauma or death. I assume the risks of the activities identified herein and other risks not specifically identified. I relieve OE of any responsibility or duty it may have to protect me from all such risks. In addition, I expressly surrender and release OE from any and all claims I have or may have, including the right to file a lawsuit or make any demand of OE for personal injury, property damage, wrongful death, breach of contract, products liability, or any other claim or loss arising out of my or my child's or ward's participation in any OE activity, even if caused by the negligence of OE.

▶ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relation to Participant \_\_\_\_\_

**CONSENT TO TREAT**

I give my consent for OE field volunteers, personnel, staff, and qualified medical personnel to treat me in an emergency situation. I agree to pay for medical treatment and transportation costs incurred on my behalf.

▶ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relation to Participant \_\_\_\_\_

**PHOTO RELEASE (OPTIONAL)**

I authorize OE to publish, display, or use all photographs in which I appear, without limitation.

▶ Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Relation to Participant \_\_\_\_\_