SIERRA CLUB OUTINGS

Medical Form

Please complete this form and return it to your leader within 30 days.

Please fill in this form as accurately as possible, it is essential for Leaders to evaluate individual and group health needs as part of trip planning, and for use during emergencies. The information will remain confidential, and then be destroyed. Your Leader may follow-up by phone or email.

General Information

Trip Number_____

Name:_____ Age:_____ Date of Birth_____

Height_____ Weight:_____ Gender:_____ Blood Pressure_____/_____ Resting Heart Rate:_____ bpm

Address:_____ Email:_____

City:_____ State:_____ Zip:_____

Mobile Phone:_____ Home Phone:_____

Primary Emergency Contact:_____ Relationship:_____

Home:(_____) Work:(_____) Mobile: (_____)

Secondary Emergency Contact:_____ Relationship:_____

Home:(_____) Work:(_____) Mobile: (_____)

Evacuation and Medical Insurance

We strongly encourage you to have medical and evacuation insurance and to bring your insurance card or other documentation with you on the trip.

Evacuation Insurance	Medical Insurance
Company Name: Policy Number: Contact Phone Number: Coverage Amount:	Company Name: Policy Number: Contact Phone Number:

Allergies

Include allergies to food, insect bites and stings, medicines, animals and environment (dust, pollen, etc.)

Select ☐ NO ALLERGIES – if none.

Allergy	Reaction	Medication Required

Medications

Please list all prescription, over the counter, and natural medications you are currently taking. Note if this is a recent change in dosage or prescription. ***Use separate sheet if needed.***

Medication Name	Dosage	Frequency	Side Effects (known and potential)	Reason for Taking

General Medical History

Please answer the following medical history questions. ***If answering YES**, **use a separate sheet to explain history in more detail.***

Do you currently have, or have a history with, the following conditions:

Respiratory problems, Asthma, Do you smoke YES ☐ NO ☐

Diabetes YES ☐ NO ☐

Gastrointestinal problems YES ☐ NO ☐

Cardiac problems, Hypertension YES ☐ NO ☐

Neurological problems, Seizures YES ☐ NO ☐

Vision or Eye problems YES ☐ NO ☐

Hearing problems YES ☐ NO ☐

Bone, Joint, Muscle Problems YES ☐ NO ☐

Head trauma , Traumatic Brain Injury YES ☐ NO ☐

Substance Abuse, Anxiety, Depression YES ☐ NO ☐

If female, are you pregnant YES ☐ NO ☐

Have you had a recent illness within the last 12 months YES ☐ NO ☐

Have you had surgery or been hospitalized in the last year YES ☐ NO ☐

Have you ever had problems related to exposure with altitude YES ☐ NO ☐

Any other Health complaint or medical issue that would affect your participation on this trip YES ☐ NO ☐

If yes, Please explain _____.

Date of last tetanus immunization: _____ Please describe your swimming ability: _____

Date of most recent physical: _____ Physician's name: _____

Address: _____ Phone: _____

Please have physician sign if required by your Leader to obtain a physical prior to trip

Physician's signature: _____ Date _____

The information provided here is a complete and accurate statement of any physical and psychological conditions that may affect my participation on this trip. I realize that failure to disclose such information could result in serious harm to myself and other participants. I agree to inform my trip leader should there be any changes to my health status prior to the start of the trip. I understand the outing may require vigorous activity that is both physically and mentally demanding in isolated areas without medical facilities. **I am fully capable of participating on this trip**.

Trip Name _____ **Trip Dates** _____

Participant Signature _____ **Date** _____