

# CONSENT FOR MEDICAL TREATMENT & PHYSICAL EXAM



Name \_\_\_\_\_ Sex  Male  Female

Street Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Dietary Restrictions (please explain) \_\_\_\_\_

Father's Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_

Work/Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Home Phone \_\_\_\_\_

Work/Cell Phone \_\_\_\_\_

*Alternate person to be reached in the event of an emergency, if parents are unavailable:*

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

## EMERGENCY MEDICAL INFORMATION

Name of Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address & Phone Number: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Student's SS#: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

## CONSENT FOR MEDICAL TREATMENT & RELEASE OF INFORMATION

CONSENT IS HEREBY GIVEN FOR THE STUDENT TO ATTEND A WILLIWAW ADVENTURES PROGRAM. I AUTHORIZE THE DIRECTORS OF WILLIWAW ADVENTURES LLC AND INSTRUCTORS, OR HEALTH CARE PROVIDERS CONSIDERED APPROPRIATE BY HIM OR HER TO CARRY OUT ANY EMERGENCY ANESTHESIA, OPERATION, HOSPITALIZATION OR OTHER TREATMENT WHICH MAY BECOME NECESSARY. THIS CONSENT IS AUTHORIZED WITH THE UNDERSTANDING THAT EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT/GUARDIAN IN THE EVENT OF ANY EMERGENCY OR ILLNESS.

I UNDERSTAND THAT ALL INFORMATION WILL REMAIN CONFIDENTIAL, AND I AUTHORIZE THE RELEASE OF INFORMATION TO ANY HEALTH FACILITY THAT MAY TREAT MY CHILD. • WE UNDERSTAND THAT IN ORDER TO ENSURE THE SUCCESS AND SAFETY OF A TRIP, IT IS IMPERATIVE THAT ALL PRE-EXISTING MEDICAL AND PSYCHOLOGICAL CONDITIONS ARE DISCLOSED, AND WE HAVE DONE SO. I HAVE READ AND UNDERSTAND THE CONSENT FOR MEDICAL TREATMENT & RELEASE OF INFORMATION.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

APPLICANT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

# PHYSICAL EXAM

NAME \_\_\_\_\_ AGE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

PLEASE INDICATE YOUR SWIMMING ABILITY  EXCELLENT  GOOD  POOR  CAN'T SWIM

**TO BE COMPLETED BY A PHYSICIAN:**

IF NORMAL, PLEASE INDICATE – IF NOT, PLEASE COMMENT.

THROAT, EYES, EARS & NOSE
MUSCULAR & SKELETAL SYSTEM (BACK, SPINE, ARMS, LEGS, ETC.)
CARDIOVASCULAR & RESPIRATORY SYSTEM
ABDOMEN
OTHER

DATE OF LAST TETANUS INOCULATION: \_\_\_\_/\_\_\_\_/\_\_\_\_

BLOOD PRESSURE: \_\_\_\_/\_\_\_\_

**DOES THIS PERSON HAVE, OR HAVE A HISTORY OF:**

	YES	NO		YES	NO		YES	NO
DIABETES			G I PROBLEMS			ASTHMA		
HEART DISEASE			MIGRAINES, HEADACHES			HERNIA		
HIGH BLOOD PRESSURE			SEIZURES			PLANT OR INSECT ALLERGIES		
TUBERCULOSIS			SLEEP DISORDERS			FOOD ALLERGIES		
MALARIA			DIZZINESS/FAINTING			DRUG ALLERGIES		
DERMATITIS OR RASH			KNEE/JOINT PROBLEMS			OTHER:		

**IF "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN.**

**ARE THERE ANY PERTINENT PHYSICAL OR MENTAL HEALTH CONCERNS, NOT MENTIONED ABOVE, WHICH SHOULD BE EXPLAINED (ACROPHOBIA, CLAUSTROPHOBIA, AGORAPHOBIA, SLEEP WALKING, ETC.)?**

**PLEASE LIST ALL DRUGS AND MEDICATIONS YOU ARE CURRENTLY TAKING AND CONDITION FOR WHICH TAKEN.**

**TO THE PHYSICIAN:** PERSON INTENDS TO BE INVOLVED IN A WILDERNESS EXPEDITION, WHICH WILL INVOLVE STRENUOUS PHYSICAL ACTIVITY IN REMOTE AREAS. DO YOU FEEL THAT THIS PERSON IS CAPABLE, BOTH PHYSICALLY AND MENTALLY TO UNDERTAKE SUCH AN EXPEDITION?  YES  NO

DO YOU RECOMMEND ANY RESTRICTIONS OR HAVE ANY OTHER CONCERNS?  YES  NO

IF YES, PLEASE EXPLAIN.

PHYSICIAN'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_