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 STRENOUS 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 _____