

**PLEASE COMPLETE BOTH SIDES!**

**Student Medical Information Form  
New Hampshire Outing Club**

Please complete fully so that the leaders can adjust program activities as needed to meet your needs and manage your participation and the participation of others. This information is confidential and will be shared only with medical care providers.

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

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

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

Name & Phone Number of a person to contact in case of an emergency: \_\_\_\_\_

**Medical History:**

	YES	NO		YES	NO
1) High Blood Pressure	_____	_____			
2) Heart Disease/Conditions	_____	_____	28) Leg Problem	_____	_____
3) Seizure Disorder	_____	_____	29) Knee Problem	_____	_____
4) Teeth/Mouth Problems	_____	_____	30) Ear Problems	_____	_____
5) Currently Pregnant	_____	_____	31) Fear of Heights	_____	_____
6) Bleeding Disorder	_____	_____	32) Special Diet	_____	_____
7) Asthma	_____	_____	i.e. vegetarian, lactose, etc.	_____	_____
8) Diabetes	_____	_____	33) Learning Disability	_____	_____
9) Hypoglycemia	_____	_____	34) Skin Condition	_____	_____
10) Anorexia Nervosa	_____	_____	i.e. easily sunburn, rashes, etc.	_____	_____
11) Bulimia	_____	_____	35) Other _____	_____	_____
12) Medical Devices or Equip.	_____	_____	<b>Do you currently have any of the</b>		
13) Motion Sickness	_____	_____	<b>following?</b>		
14) Frostbite	_____	_____	36) Chest Pains/Pressure	_____	_____
15) Circulation Problems	_____	_____	37) Heart Palpitations	_____	_____
16) Headaches	_____	_____	38) Unexplained Sweating	_____	_____
17) Traumatic Head Injury	_____	_____	39) Shortness of Breath	_____	_____
18) Hearing Impairment	_____	_____	40) Frequent Dizziness	_____	_____
19) Vision Impairment	_____	_____	41) Frequent Fainting	_____	_____
20) Sleepwalking	_____	_____	42) Intolerance to Heat	_____	_____
21) Broken Bone	_____	_____	43) Intolerance to Cold	_____	_____
22) Head Problems	_____	_____	44) PMS/Menstrual Problems	_____	_____
23) Neck Problems	_____	_____	i.e. chronic cramps, heavy bleeding, etc.	_____	_____
24) Arm Problem	_____	_____			
25) Shoulder Problem	_____	_____	45) Have you had any surgery?	_____	_____
26) Foot Problem	_____	_____	46) Other Medical Disorders	_____	_____
27) Ankle Problem	_____	_____	47) Other _____	_____	_____

**Please elaborate on any answered Yes**

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**Allergies:** (including food, medicines, bites/stings) if none, please write "NONE"

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**Medications:** (prescription and over the counter) if none, please write "NONE"

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**Other:** is there anything else we should know about? Please indicate any injuries, medications, allergies, problems, etc. that have not been covered. If so, please explain in detail. if none, please write "NONE"

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**Physician:** Are you currently being treated by a physician? Have you been in within the last year? Have you been hospitalized in the past year? If so, please explain. If not, please write "NO"

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**Primary Physician:** Address and Phone Number

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**Insurance:** What Insurance company are you covered by? If possible please include your ID number. If covered by University of New Hampshire insurance than please indicate here.

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Please notify us if there are any changes to health and fitness which occurs before or during the program.

I declare that the information provided is complete and correct. If any information is not disclosed, I fully understand that my participation in the program can be adjusted or terminated. In case of illness or injury, I give permission to be treated.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_