

Health Form

Health Disclosure: NCOAE programs involve a variety of activities including warm-ups, group initiative problems, and hands on application of medical training. Some programs may also include other rigorous physical adventure activities such as backpacking, climbing, surfing, paddling, swift water rescue, swimming, or hiking. These activities are designed to be within the limits of a person who is in reasonable good health. The level of participation in all programs and activities is at all times completely up to the individual. Safety is a high priority in all programs. In addition, each participant must assume the risk that he or she may suffer an emotional or physical injury and disability. Each participant must have health/accident insurance coverage. The information requested on this form is intended to help alert staff to pre-existing medical conditions. Misinformation could result in an injury or may compound the severity of an injury. This information will be held in confidence. Please complete this form to complete your enrollment.

Name: _____ **Date of Birth:** ____/____/____ **Gender:** _____
Height: _____ **Weight:** _____ **Shoe Size:** _____ **Shirt Size:** XS S M L XL XXL **Pant Size:** XS S M L XL XXL

| Medical Questionnaire | YES | NO |
|--|-----|----|
| Do you have any limiting health disabilities – temporary or permanent – that you or your doctor feel would limit your participation in a NCOAE activity? | | |
| Do you have any chronic or recurring injuries? | | |
| Are you currently taking any medication? | | |
| Do you have any allergies or reactions to any medications, foods, plants, or insects? | | |
| Have you had surgery in the past year for any condition, which may limit your participation? | | |
| Do you have asthma? | | |
| Do you have diabetes? | | |
| Are you pregnant? | | |
| Dietary Restrictions? | | |

If “yes” to any of the medical conditions above, please explain/describe below:

Do you have health/medical insurance? Yes No If “yes,” please give name and address of insurance company below:

| Medical History | YES | NO |
|--|-----|----|
| Do you have high blood pressure? | | |
| Are you currently on medication for high blood pressure? | | |
| Do you experience heart palpitations? | | |
| Do you experience chest pain or pressure? | | |
| Have you ever had a heart attack? | | |
| Do you have heart disease? | | |
| Do you have a heart murmur? | | |
| Have you ever had a stroke? | | |

If “yes” to any of the above, please explain/describe below:

We strongly recommend that you consult your physician if you are pregnant or have checked off any of the conditions above before participation in NCOAE activities.

Please list below any other concerns or conditions that may affect your participation:

| Emergency Contact Information | | | |
|-------------------------------|-------|-----------------|--|
| Name: | | Relationship: | |
| Address: | | | |
| Phone(s) Cell: | Work: | Home: | |
| Email Work: | | Email Personal: | |