



# Health Information Form Form Revised 1/2025

PLEASE PRINT

Please read and complete the entire form, front and back, carefully. You must complete and sign **both** this form and the Participant Agreement Form in order to participate. Incomplete or missing information and/or signature will prevent participation.

<b>Participant</b>	Name of Participant _____	Date of Birth (Month/Day/Year) _____	Age _____	Sex _____
	Home Address _____	City _____	State _____	Zip _____
	Cell Phone of Parent/Guardian _____	Email of Parent/Guardian _____	Height _____	Weight _____

<b>Emergency Contact</b> Parent/Guardian	Emergency Contact Name / Relationship _____	Emergency Cell/Phone _____
	Emergency Contact Address _____	City _____ State _____ Zip _____

<b>Health Insurance</b>	Participant's Family Physician Name _____	Physician's Phone _____
	Health Insurance Company _____	Health Insurance ID Number _____ Health Insurance Phone _____

**Health History** Directions: Check YES or NO if the participant "currently has" or "has a history of" the following conditions. Please explain all "yes" answers, and contact us with any concerns regarding the impact of activities with relation to the below medical history.

General Medical History

Yes No

Heart problems, Low/High blood pressure? Explain: \_\_\_\_\_

Diabetes? Explain: \_\_\_\_\_

Respiratory problems? Asthma? Explain: (please note if you carry an inhaler, what triggers an attack? last episode? ever hospitalized?) \_\_\_\_\_

Allergies? (Bees, Medications, Foods, etc.) Explain: (please specify what you are allergic to, note last episodes) \_\_\_\_\_

Gastrointestinal conditions, dietary restrictions? Explain: \_\_\_\_\_

Neurological problems? Epilepsy? Seizures? Explain: \_\_\_\_\_

Migraines, dizziness, fainting spells? Explain: (please describe the frequency, date of last episode, severity) \_\_\_\_\_

Current communicable disease? Explain: \_\_\_\_\_

Behavioral disorders? Explain: \_\_\_\_\_

\_\_\_\_\_

Other Pertinent conditions? Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes No Muscle/Skeletal Injuries/Fractures

Recent sprains, fractures, or dislocations? Explain: \_\_\_\_\_

Shoulder, arm or back injuries? Explain: \_\_\_\_\_

Knee, hip or ankle injuries and/or surgery? Explain: \_\_\_\_\_

Head injury or surgery? When did this occur occur? Explain: \_\_\_\_\_

Is there limited range of motion? Explain: \_\_\_\_\_

Yes No Fitness Information

Does the applicant exercise regularly?  
What activity? \_\_\_\_\_

Swimming Ability:  
Non-Swimmer  Swimmer

**\*\*We are unable to take women rafting during pregnancy.\*\***

Yes No Female Participants ONLY:  
Is the applicant currently pregnant?  
Please list any pertinent information regarding menstrual cycles:  
\_\_\_\_\_  
\_\_\_\_\_

Immunizations should be kept current, please list any pertinent information we should be aware of regarding: Tetanus, Mumps, Measles, Rubella, Hepatitis A & B immunizations.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Yes No Note pertinent Cold, Heat, Altitude Illness Information

Frostbite, hypothermia related illness?  
Explain: \_\_\_\_\_

Heat stroke or other heat related illness?  
Explain: \_\_\_\_\_

Altitude related illness?  
Explain: \_\_\_\_\_

Prescription Medications:  
In the space below please list out all current prescription medications being used, include name of the medication, dosage, side effects, prescribed by, for what conditions? **(This same information must be included with the medications)**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Over-the-Counter Medications:  
Some "over the counter" (OTC) medications are available for underage participants, but only with parent/guardian consent. If you would like your student to have access to **ALL** OTC medications, please initial here \_\_\_\_\_ for "YES".  
But, if you would prefer to only have certain medication made available, check **ONLY** those boxes below.

<input type="checkbox"/> 100% Aloe vera gel	<input type="checkbox"/> Anti-diarrhea medicine	<input type="checkbox"/> Antihistamine/Allergy medication
<input type="checkbox"/> Tecnu cream for poison oak	<input type="checkbox"/> Nasal decongestant	<input type="checkbox"/> Blistex/Lip ointment
<input type="checkbox"/> Hydrocortisone anti-itch creme	<input type="checkbox"/> Acetaminophen/Tylenol (extra strength)	<input type="checkbox"/> Pepto-Bismol/Indigestion medicine
<input type="checkbox"/> Eye wash	<input type="checkbox"/> Ibuprofen/Advil	<input type="checkbox"/> Metamucil/Fiber laxative
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Naproxen sodium/Aleve	

**Consent for Treatment**

In the event of a medical emergency, I hereby give permission to YD staff to administer or obtain medical treatment, which may include hospitalization, surgery, ordering of injection, administering of anesthesia, or taking of medication(s) for the minor participant or me. I authorize YD staff and the third party medical care provider to exchange medical information pertinent to the care sought. I agree to pay all the costs of rescue and medical services incurred on my or the child's behalf.

Participant's Printed Name \_\_\_\_\_ Participant's Age \_\_\_\_\_

Signature (18 years & older): \_\_\_\_\_  
Participant's Signature OR Parent/Guardian's Signature \_\_\_\_\_ Date Signed \_\_\_\_\_