



## Unity College Participant Information and Health History

Name: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### In case of emergency contact:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Personal Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Insurance: \_\_\_\_\_ Group/Policy#: \_\_\_\_\_

### Medical History

**Date of your last Tetanus shot:** \_\_\_\_\_ If not within the last ten years you must have a booster of the vaccine before you can attend classes or Nova.

### Do you currently have or have you had a history of:

Asthma/respiratory problems	_____	Arthritis	_____
Diabetes	_____	Bleeding or Blood disorders	_____
High/low Blood pressure	_____	Neurological problems	_____
Hepatitis	_____	Cardiac problems	_____
Epilepsy/Seizures	_____	Treatment for menstrual cramps	_____
Urinary Tract disorders	_____	Loss of unconsciousness	_____
Dizziness/lightheadedness	_____	Learning disorders	_____
Migraines	_____	Recent illness/surgery	_____
Stomach problems	_____		

Please describe history for any of the conditions checked above including symptoms, date of last occurrence, current restriction, etc.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Allergies

(medication, food or environmental allergies)

Allergies	Reaction	Medication Required
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Medications

<b>Current Medications</b>	<b>Condition</b>	<b>Dosage</b>	<b>Side Effects</b>
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\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Cold and Heat

History of frostbite or Raynaud's syndrome? Yes \_\_\_\_ No \_\_\_\_

History of heat stroke or heat related illness? Yes \_\_\_\_ No \_\_\_\_

**Please describe conditions:**

\_\_\_\_\_  
\_\_\_\_\_

**Muscular/Skeletal Injuries**

**Do you currently have or have you had a history of:**

Knee, hip, or ankle injuries \_\_\_\_\_ Shoulder, arm, or back injuries \_\_\_\_\_  
 Joint problems \_\_\_\_\_ Head injury \_\_\_\_\_

Please describe history for any of the conditions checked above including symptoms, date of last occurrence, current restrictions, etc.

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**Other**

Do you intend to be on a weight loss diet during the trip/course? Yes \_\_\_ No \_\_\_  
 Have you ever been treated for an eating disorder? Yes \_\_\_ No \_\_\_  
 Do you use a corrective brace or device (hearing, walking, etc)? Yes \_\_\_ No \_\_\_  
 Do you wear glasses or contact lenses? Yes \_\_\_ No \_\_\_  
 Do you have any dietary restrictions? (Vegan/Vegetarian etc. ) \_\_\_\_\_

Is there anything else we should know about you? (Phobias, special sensitivities, etc.)

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**The following questions are important for you to read and think about, although you are not required to answer them. If you do choose to answer these questions your information will be kept confidential and will only be seen by your trip leaders, class instructor, the Director of Health Services and the Counselor.**

Do you currently take any psychotropic medications? (i.e. antidepressants, anti-anxiety medication, anti-psychotics, mood stabilizers) Yes \_\_\_ No \_\_\_  
 If so, are you being seen by a psychiatrist, counselor or family physician? Yes \_\_\_ No \_\_\_  
 Will you need continuing support once you are at Unity College? Yes \_\_\_ No \_\_\_

By signing here, I agree that the above questions are answered accurately and completely. I recognize that some outdoor activities are very strenuous and may be the hardest thing I ever do.

I further authorize medical treatment, hospitalization and emergency transportation for myself as deemed necessary by the trip leaders.

I recognize that the cost of medical treatment, emergency transportation, and hospitalization may need to be covered by myself or by my insurance provider.

Signature of participant: \_\_\_\_\_ Date: \_\_\_\_\_

**For participants under 18 years of age:**

If there is an emergency and I cannot be reached, Unity College has my permission to authorize medical treatment, emergency transportation, and hospitalization.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Updated Date: _____ Initials _____	Updated Date: _____ Initials _____	Updated Date: _____ Initials _____	Updated Date: _____ Initials _____	Updated Date: _____ Initials _____
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