



TO BE COMPLETED BY STUDENT or PARENT/S (if student is under 18)

The High Mountain Institute collects medical information to endeavor to provide more successful experiences and to assist in managing the risks faced by our students. HMI's programs vary greatly in environmental conditions, physical difficulty, and access to professional medical care. Please contact us if you have questions about these issues or the activities and risks associated with your specific program as you complete this form. HMI treats all personal medical information with some degree of confidentiality. Enrolled student medical information is shared with the faculty, apprentices and adjunct faculty who oversee the students on campus and in the field for a particular program.

STUDENT NAME	HMI Program	Today's Date
Student's DOB	Age	Gender
<u>Mother/Guardian Contact Info</u>		<u>Father/2nd Guardian Contact Info</u>
Full Name	Full Name	
Day Phone	Day Phone	
Eve Phone	Eve Phone	
Cell Phone	Cell Phone	
E-Mail	E-Mail	

GENERAL HEALTH QUESTIONS: Please read the items in each column carefully and respond to each item (YES, NO or N/A – not applicable) regarding any **past or current** medical issues or concerns regarding the condition/problem/illness/area listed:

Please select "YES" or "NO" to each item in this column:	YES	NO	Please select YES, NO, or N/A for this column:	YES	NO	N/A
ALLERGIES Bee/insect stings, Shell Fish, Iodine, nuts, dairy, other foods, pollen, medications, and any other known allergies. A "NO" response means "No Known Allergies" (NKA)! <i>If "YES" please explain below in detail</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Addiction and/or regular use of alcohol or drugs * CALL Altitude: Acute Mountain Sickness (AMS) High Altitude Cerebral Edema (HACE) * CALL High Altitude Pulmonary Edema (HAPE) * CALL Bleeding, Blood Disorders, Tuberculosis, Hepatitis Cancer			
ATTENTION DEFICIT (HYPERACTIVITY) DISORDER Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and other related issues <i>If "YES" please explain below</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Cardiac (heart) Abnormalities or Problems Circulatory Problems Cold Injuries Dental Problems/Issues			
MEDICATIONS Prescription Medications, Over-the-Counter Medications, Dietary Supplements, Herbal remedies, and any other medications. <i>If "YES" please list below</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Diabetes * CALL Ear, Eye, Nose & Throat Infections/Issues/Problems Eating Disorder (anorexia, bulimia, etc.) Epilepsy or Other Seizure Disorders * CALL Fainting or Dizziness, chronic			
MENTAL HEALTH ISSUES/ILLNESS Anxiety Disorders, Depression, past history of suicide attempt or ideation, past addiction to alcohol or drugs, or any other mental health issues <i>If "YES" please explain below</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Gastrointestinal Tract, Ulcers Head Injuries, Concussions, Headaches Heat Injuries/Illness Hormonal &/or Thyroid Hypertension Kidney or Liver Disease or Issues			
ORTHOPEDIC INJURIES Shoulder, Arm, Elbow, Hand, Neck, Back, Hips, Leg, Knee, Ankle, Foot, Recurrent Strains of Particular Muscles, Recurrent Sprains of Particular Joints, Hernia, other musculoskeletal issues, and other athletic or orthopedic Injuries. <i>If "YES" please explain below</i>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Menstrual Cramps Neurological Disorders Pregnancy, current * CALL Reproductive Tract Respiratory Tract Skin Problems/Issues Sleepwalking			
			Sudden death under age 50 of family member * CALL Syncope with exertion (fainting during exercise) * CALL Tobacco regular use and/or addiction * CALL Urinary Tract Vision Other (explain): Call HMI immediately regarding any "yes" answer for the "* CALL" issues above. For any "YES" answers in this column, provide explanation and clarification below.			

For each "YES" item from the right hand column above, please fully explain the history, current status, and note the treating physician's name and #'s at the end of this form or on a separate sheet.



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Have you been under the care of a physician in the last 12 months? If "Yes", please explain why:

Two horizontal lines for text entry.

Considering the information you have provided above or otherwise, does the student have any condition/s (e.g. mental, physical, emotional) which might affect or limit his or her well-being, the well-being of others, or the student's ability to engage in HMI activities?: Please include any adaptations or modifications appropriate or necessary.

Two horizontal lines for text entry.

Date of last tetanus immunization: _____

Do you have medical insurance (Circle one)? Yes No

Medical Insurance Carrier: _____

Policy/Group #: _____

ATTENTION - SIGNATURE REQUIRED! One or both parent/s of the student, or the student, if an adult (those 18 yrs. of age or older) must sign below for both the Acknowledgment/Agreement and Emergency Authorization: ACKNOWLEDGMENT/AGREEMENT:

To the best of my knowledge, this medical form contains accurate information. I understand the nature of HMI activities, and acknowledge that I can contact HMI should I have any questions about these activities or the physical or emotional demands of these activities. Other than any limitations described in this form, the student agrees, and has permission from his or her parent/s if he or she is a minor, to participate in all HMI activities. I agree to contact HMI if any medical or health condition changes before the start of the HMI program. I understand that providing inaccurate medical or health information or falsifying medical or health information can create serious risks to the student or others, and/or can result in the student's dismissal from the program. I understand the student's ability to participate is contingent upon HMI representatives' review of all forms, including this one. I understand that although HMI will review this information and may allow participation, HMI cannot anticipate or eliminate risks or complications posed by a student's mental, physical, or emotional condition.

EMERGENCY AUTHORIZATION:

I authorize HMI staff, representatives or other medical personnel to obtain or provide medical care for me/my child, to transport me/my child to a medical facility, and/or to render treatment (including, but not limited to hospitalization, medications, injections, anesthesia, or surgery) they consider necessary for my/my child's health. I agree to the release (to or by HMI) of any records necessary for treatment, referral, billing, or insurance purposes. I agree that HMI has no responsibility for medical care provided to me/my child, and agree to pay all costs associated with such care. This form may be photocopied for use in the field.

Student Name (printed): _____ Student Signature: _____ Date: _____
(if 18 yrs. or older)
Parent/Guardian Name (printed): _____ Parent/Guardian Signature: _____ Date: _____
2nd Parent/Guardian Name (printed): _____ 2nd Parent/Guardian Signature: _____ Date: _____

Additional Notes: _____

