

# High Mountain Institute Medical Information Form

|                                    |                    |
|------------------------------------|--------------------|
| <b>Course/Program Title:</b> _____ |                    |
| Name _____                         |                    |
| Address _____                      |                    |
| _____                              |                    |
| Day Phone _____                    | Eve. phone _____   |
| <b>Emergency Contact</b>           |                    |
| Name _____                         | Relationship _____ |
| Address _____                      |                    |
| _____                              |                    |
| Phone #'s: _____                   |                    |

Please list any operations: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List any allergies to medicines, food, or insect bites: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

List all current prescription or non-prescription medications and dosages:

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

Please list any mental or physical problems or issues that might limit your ability to participate in strenuous activity: \_\_\_\_\_  
 \_\_\_\_\_

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

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

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

Are you currently under treatment, including medications? (Please explain): \_\_\_\_\_  
 \_\_\_\_\_

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

Describe any prior medical history that may affect your ability to participate: \_\_\_\_\_  
 \_\_\_\_\_

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

Date of last tetanus immunization: \_\_\_\_\_

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

Medical Insurance Carrier: \_\_\_\_\_

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

***Please read and sign below:***

By signing below I/we attest that this health history is correct to the best of my knowledge.

Emergency Authorization: I hereby give permission to the medical personnel selected by the faculty, staff, designated subcontractor, or directors of the High Mountain Institute to order X-rays, routine tests and treatment for me in the event I cannot give consent. I hereby give permission to the physician selected by the High Mountain Institute to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for me. This form may be photocopied for use in the field.

Signature of Participant/Student: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian #1 (if under 18 years of age): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian #2 (if under 18 years of age): \_\_\_\_\_ Date: \_\_\_\_\_