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

Parent/Guardian Contact Info OR Emergency Contact Info if over 18	2nd Parent/2nd Guardian Contact Info
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
ALLERGY and/or DIETARY RESTRICTIONS Bee/insect stings, shellfish, iodine, nuts, dairy, other foods, pollen, medications, and any other known allergies. Dietary restrictions including medical, religious, or ethical. ***If "YES" complete the ALLERGY /DIETARY RESTRICTIONS Form***	☐	☐
ATTENTION DEFICIT (HYPERACTIVITY) DISORDER Attention Deficit Disorder, Attention Deficit Hyperactivity Disorder, and other related issues or learning disorders ***If "YES" please complete the ADD/ADHD Form***	☐	☐
MEDICATIONS Prescription medications, over-the-counter medications, dietary supplements, herbal remedies, and any other medications ***If "YES" please complete the MEDICATIONS Form***	☐	☐
MENTAL HEALTH ISSUES/ILLNESS Anxiety disorders, depression, past history of suicide attempt or ideation, past addiction to alcohol or drugs, self-abuse, or any other mental health issues ***If "YES" please complete the MENTAL HEALTH Form***	☐	☐
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 ***If "YES" please complete the ORTHOPEDIC Form***	☐	☐

For each "YES" item, please fully explain the history, current status, and note the treating physician's name and phone number on the next page

Please select YES, NO, or N/A for this column:	YES	NO	N/A
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			
Asperger's, Autism or PDD			
Bleeding, Blood Disorders, Tuberculosis, Hepatitis			
Cancer			
Cardiovascular (heart and vessels) Abnormalities or Problems, including high blood pressure			
Circulatory Problems			
Cold Injuries			
Dental Problems/Issues			
Diabetes ∗ CALL			
Ear, Eye, Nose & Throat Infections/Issues/Problems			
Eating Disorder (anorexia, bulimia, etc.)			
Epilepsy or Other Seizure Disorders ∗ CALL			
Fainting or Dizziness, chronic			
Gastrointestinal Tract, Ulcers			
Head Injuries, Concussions, Headaches			
Heat Injuries/Illness			
Hormonal &/or Thyroid			
Hypertension			
Kidney or Liver Disease or Issues			
Menstrual Cramps			
Neurological Disorders			
Pregnancy, current ∗ CALL			
Reproductive Tract			
Respiratory Tract, including Asthma			
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 or hearing issues or impairment			
Other, including hospitalization in last 5 years (explain):			

Call HMI immediately regarding any "YES" answer for the "∗ CALL" issues above.

HMI

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

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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.

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Date of last tetanus immunization: ______________________________________

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

Medical Insurance Carrier: ____

Policy/Group #: ____

Additional Notes: ____

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

ATTENTION – SIGNATURE REQUIRED! One or both parent/s of the student, or the student if an adult (those 18 years of age or older), must sign below for both the Acknowledgment/Agreement and Medical Authorization:

ACKNOWLEDGEMENT/AGREEMENT

To the best of my knowledge, this medical form and any supplemental medical information I submit (any supplemental information incorporated by this reference) 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 associated physical, mental or emotional demands or other concerns. Other than any limitations described in this form (or in information submitted by the student's health care provider/s), 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 final acceptance and participation in the program 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. I understand that emergency, medical, drug and/or health issues, response, assessment or treatment are included within the scope of – and expressly subject to the terms of – the HMI Acknowledgment and Assumption or Risks & Release and Indemnity Agreement. Please review that Document carefully in regard to the activities, risks and your responsibilities.

Note: I consent here to allow HMI staff or its consulting health care providers to contact and communicate with the student's health care provider/s listed in these forms about the student's health and medical condition or care. HMI keeps and provides regular over-the-counter medications for minor illness (headaches, cramps, cold & flu, sore throat, etc.) and asks that students do not bring them. Signing this Acknowledgement/Agreement gives HMI permission to administer over-the-counter medications.

MEDICAL AUTHORIZATION:

I authorize HMI staff, representatives and/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 provide 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 this care, including but not limited to medical evacuation, travel, compensation and expenses for staff accompanying the student, medicine and treatment. This form may be photocopied for use in the field.

Student Name (printed): ____________________ Student Signature: ____________________ Date: __________

Parent/Guardian Name (printed): ____________________ Parent/Guardian Signature: ____________________ Date: __________

2nd Parent/Guardian Name (printed): ____________________ 2nd Parent/Guardian Signature: ____________________ Date: __________