HEALTH DISCLOSURE

In the event of any medical emergency (physical or mental), Student hereby grants to System or any of its representatives of the Recreational Sports Program ("Program") the full authority to take any action deemed necessary to protect Student's mental or physical health and safety at Student's own expense, including, but not limited to, placing Student under the care of a doctor or hospital or any place for medical examination and/or treatment or returning the Student to the United States at Student's own expense if such return is deemed necessary after consultation with medical authorities. In the event Student is returned to the United States, Student shall not recover any money paid for an in connection with the Program. Student agrees System is not required to take any such actions if it is not aware of the emergency or in its discretion determines no emergency exists. Should the need arise, System is authorized to provide any personal information of Student to any healthcare provider.

Please read these forms and follow all instructions for completion. **FULL DISCLOSURE IS REQUIRED. The information on these forms will assist healthcare providers in the event of a medical emergency. It is very important that all sections are cully and accurately completed. If a question is not applicable, enter N/A**.

STUDENT NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ BUSINESS PHONE: _____

First Emergency Contact:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Second Emergency Contact:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Primary Care Physician:

Name: _____ Office Phone: _____

Insurance Carrier: _____ Policy Number: _____

PARTICIPANT'S GENERAL INFORMATION STATEMENT AND AUTHORIZATION FOR MEDICAL TREATMENT

Part I

I (Participant) consider myself adequately, physically, and mentally healthy to take full responsibility in case of illness or disability, and I prefer not to supply the following information.

Participant's Signature _____ Date _____

NAME OF PROGRAM: _____

Name _____ Date of Birth ___/ ___ /___
Last First Middle Initial MM/DD/YY

SOCIAL SECURITY NUMBER _____

DRIVER'S LICENSE NUMBER _____

NAME OF SPOUSE, PARENT OR GUARDIAN _____

ADDRESS _____

TELEPHONE ____/_____ _____/_____
Day Evening

Participant's Signature: _____

Date _____

PARTICIPANT'S GENERAL INFORMATION STATEMENT AND AUTHORIZATION FOR MEDICAL TREATMENT
Part II

MEDICAL CONDITIONS:
MEDICAL HISTORY/HEALTH DISCLOSURE

All questions must be answered. (Please circle correct response.) For each "Yes," provide an explanation in the area provided below. Attach an additional sheet if necessary.

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

Allergies to foods?	NO	YES
Allergies to medications?	NO	YES
Allergies to plants, animals, or insects?	NO	YES
Altitude sickness?	NO	YES
Anaphylactic reactions?	NO	YES
Arthritis?	NO	YES
Asthma	NO	YES
Bleeding disorders?	NO	YES
Cardiac/circulatory problems?	NO	YES
Chemical (drugs, alcohol, etc.) abuse or dependency?	NO	YES
Diabetes?	NO	YES
Eating disorders (including anorexia and/or bulimia)?	NO	YES
Endocrine problems?	NO	YES
Epilepsy?	NO	YES
Frostbite or abnormal intolerance to cold temperatures?	NO	YES
Gastrointestinal problems?	NO	YES
Heat exhaustion/heat stroke or abnormal intolerance to hot temperatures?	NO	YES
High Blood Pressure	NO	YES
Hypoglycemia	NO	YES
Hypertension?	NO	YES
Knee, ankle, back, or other skeletal problems including, but not limited to, sprains, fractures, or operations?	NO	YES
Liver dysfunction?	NO	YES
Lymphatic problems?	NO	YES
Menstrual cramps?	NO	YES
Muscular problems?	NO	YES
Neurological problems?	NO	YES
Premenstrual syndrome?	NO	YES
Psychiatric treatment or psychological counseling?	NO	YES
Reproductive organ problems?	NO	YES
Respiratory problems including, but not limited to, asthma, chronic bronchitis or allergies?	NO	YES
Thyroid problems including allergy to iodine?	NO	YES
Urinary tract disorders?	NO	YES
Are you currently pregnant?	NO	YES
Are you currently seeing a doctor or health specialist?	NO	YES
Are you currently taking any non-prescription medications?	NO	YES
Are you currently taking any prescription medications?	NO	YES
Do you have any dietary restrictions?	NO	YES
Do you wear contact lenses?	NO	YES

Please use this space to completely explain all "Yes" answers. Use additional paper if necessary. Be advised that some medical conditions may require a doctor's approval for participation in this course/activity.

_____
_____
_____
_____
_____
_____
_____
_____

Please list any allergies or allergic reactions to antibiotics or other medications of the above named Participant:

_____

_____

_____

Please list any medications the above named Participant is currently taking:

_____

_____

_____

Date of Participant's most recent Tetanus shot: _____

List any muscle injuries you have had: _____

List any bone or joint injuries you have had: _____

List any muscle, bone or joint pain you are currently experiencing: _____

_____

Specify any medications you are currently taking: _____

_____

Specify any activities a physician has advised you to avoid: _____

_____

Do you smoke: _____ Yes _____ No If yes, how much? _____

Are you pregnant or have you had a baby in the past six months? _____ Yes _____ No

Do you have any other health condition(s) that might limit your participation in this class/activity?
__ Yes __ No If yes, please specify:

_____

_____

Other pertinent medical information: _____

_____

_____

Immunization for any disease is not required by the United States or any country we will be entering. HCC advises Participant to check with Participant's physician and abide by their recommendations. Please list any immunizations Participant has taken and list the dates of immunization.

_____

_____

_____

I verify that all information provided in this medical history health disclosure is, to the best of my knowledge, complete, accurate, and true.

Signature _____ Date _____