Appalachian Mountain Club – A Mountain Classroom
Confidential Health Questionnaire (two-page form)

Participant Name: _____
First Middle Last

School/Organization Name: _____ **Program Start Date:** _____

Age _____ **DOB:** _____ **Height:** _____ **Weight:** _____ **Gender** _____
Month/Day/Year

Home Address: _____
Street City State Zip code

Emergency Contact: _____ _____
Name Relationship

Emergency Contact's Phone #s: _____ _____ _____
Day Evening Cell

2nd Emergency Contact: _____ _____
Name Relationship

2nd Emergency Contact's Phone #s: _____ _____ _____
Day Evening Cell

Medical Insurance # _____ **Policy #** _____ **Carrier's Name** _____

DIETARY RESTRICTIONS: Do you have any dietary restrictions? ❑ Yes – list below ❑ No

Please be specific: (food allergies, iodine/seafood allergy, vegetarian, no red meat, vegan, lactose intolerant, strong food dislikes, etc.) _____

HEALTH QUESTIONNAIRE

Parent or legal guardian should complete form for all children under 18 years participating in AMC program.

1. **Have you experienced an asthma attack at any time in your life?** **❑ Yes ❑ No**
   If Yes: Will you be carrying your inhaler on the program? _____
   How often do you use your inhaler to treat asthma or wheezing? _____

2. **Have you ever been diagnosed with type I or type II diabetes?** **❑ Yes ❑ No**
   If Yes: Do you have poor or reduced circulation due to your diabetes? _____
   Will you be carrying insulin or wearing an insulin pump during the program? _____

3. **Have you ever experienced a serious allergic reaction, or have you ever been given a shot of epinephrine for an allergy or anaphylaxis?** ❑ **Yes** ❑ **No**
   If Yes: What are you allergic to and how does your body typically respond when exposed? (e.g. bee sting → hives) _____
   Will you be carrying or bringing epinephrine on the program? _____

4. **Have you ever experienced or received medical treatment for angina, a heart attack, or any type of heart disorder/disease?** ❑ **Yes** ❑ **No**
   If Yes: Are you able to exert yourself for more than 30 minutes without experiencing angina (chest pain)? _____

5. **Have you ever been diagnosed with or are you currently being treated for high blood pressure?** ❑ **Yes** ❑ **No**
   If Yes: Is your blood pressure currently under control (i.e. systolic under 140 and diastolic between 60 and 100? _____

6. **Have you ever experienced a seizure, or are you currently being treated for any type of seizure disorder?** ❑ **Yes** ❑ **No**
   If Yes: Are you currently talking medication for your seizures? _____
   Have you experienced a seizure within the past year? _____

7. **Is there anything else you think we should know about your medical background?** (i.e., anything that could affect your safety or ability to participate fully?) ❑ **Yes** ❑ **No**

_____
_____
_____

<u>PLEASE READ CAREFULLY!</u> Participants (or parents/guardians, if appropriate) must read and sign below.

Participant acknowledgement of accuracy and understanding. By signing this form, I am declaring that, to the best of my knowledge, I have completed the questionnaire accurately. I also understand that by knowingly filling out the form inaccurately, or by withholding pertinent information about my health, I could potentially be increasing the risk to myself or others.

Consent to accept aid. By signing this form, I am giving consent and permission for AMC staff, volunteers, representatives, or contractors to provide medical care to me or to my child, to transport me or my child to a medical facility or to seek the aid of emergency medical services as deemed appropriate. I further authorize AMC staff, volunteers, representatives, or contractors to render whatever treatment they consider necessary for my or my child's health, and I agree to pay all costs associated with that care and transportation.

_____	_____
Participant's name (printed)	Participant's signature
_____	_____
Signature of parent/guardian (if applicant is under 18)	Date