**Central Michigan University Field Safety**

**Field Trip Health Information Form**

The purpose of this form is to gather information that may be needed in the event of an injury or accident during field activities. Information on the form may be reviewed by the designated Field Trip Leader(s) but will be kept strictly confidential and will only be released to others in case of an emergency. Forms will be returned to each participant or destroyed at the end of the field program.

*If you have a serious health issue or concern that could affect your ability to participate in field activities, it is your responsibility to inform the Field Trip Leader(s) so that appropriate precautions can be made.*

**Participant Information**

Name       Date of Birth

Address       CMU ID Number

**Emergency Contact Information**

Name       Relationship

Address

Phone Numbers: home:       work:       cell:

**Health Insurance Information**

Medical Insurance Company or Organization

Policy or Contract Number       Phone Number:

**Physician(s)**

Name

Address       Phone Number

**Specialized Training (optional)**

Do you have training or certification in any of the following areas?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Expiration Date |
| Standard First Aid |  |  |  |
| Wilderness First Aid |  |  |  |
| CPR |  |  |  |
| Lifeguarding |  |  |  |

*None of these skills are necessary to participate in the field activity. We ask this question simply to recognize the resources our groups might have available in an emergency situation.*

Please complete the **health questionnaire** on the following page then **sign** and return to your instructor.

What was the date (year) of your last **tetanus shot**?

Do you have any **pre-existing medical conditions**? Yes  No  I decline to answer

If yes, please explain:

Are you currently taking any **medications**? Yes  No  I decline to answer

(include prescription and herbal and over the counter meds):

If yes, please explain:

Do you have a **heart condition**? Yes  No  I decline to answer

If yes, please explain:

Do you have any **allergies**? Yes  No  I decline to answer

(food, insects, medications, others):

If yes, please explain:

Do you wear a **Medic Alert** tag/bracelet? Yes  No  I decline to answer

Do you have **high blood pressure**? Yes  No  I decline to answer

Do you have **asthma**? Yes  No  I decline to answer

Do you have **diabetes**? Yes  No  I decline to answer

Are you **pregnant**? Yes  No  I decline to answer

Do you have a **disability/chronic or recurring injury**? Yes  No  I decline to answer

If yes, please explain:

Do you foresee any problems participating due to

a **lack of physical exercise**? Yes  No  I decline to answer

If yes, please explain:

Please list any prior **surgeries** that might be important for emergency care.

Please list any **other concerns** or conditions that may affect your participation.

Please list any **religious or other beliefs** that may affect your medical care.

**I have investigated the demands and requirements of the field experience, and I am physically and emotionally fit to participate in the field experience. I have consulted with my physician, if necessary. I hereby authorize release of the information herein to medical personnel in case of emergency.**

Name       Date

*Signature*