# 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 ___/ ___ /___
MM / DD / YY

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NAME OF PROGRAM: _____

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

NAME OF SPOUSE, PARENT OR GUARDIAN _____

ADDRESS _____

TELEPHONE ____/_____ _____/_____
Day Evening

***Use of non-prescription drugs or alcohol on a College-sponsored trip will not be tolerated under any circumstances and may be grounds for Participant's dismissal from the Program.***

Participant's Signature: _____ Date ___/ ___ /___
MM / DD / YY

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

## MEDICAL CONDITIONS:
## MEDICAL HISTORY/HEALTH DISCLOSURE

All questions must be answered. (Please mark the appropriate 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 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 ☐ |
| Liver dysfunction? | NO ☐ | YES ☐ |
| Lymphatic problems? | NO ☐ | YES ☐ |
| Menstrual cramps? Do we really need to know this? | NO ☐ | YES ☐ |
| Muscular problems? | NO ☐ | YES ☐ |
| Neurological problems? | NO ☐ | YES ☐ |
| Premenstrual syndrome? Ditto? | 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 ☐ |
| Are you currently under the care of a doctor or health specialist? | NO ☐ | YES ☐ |
| Do you have any dietary restrictions? | NO ☐ | YES ☐ |
| Do you wear contact lenses? | NO ☐ | YES ☐ |
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| | | |
| | | |

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:

_____
_____
_____

Please list any medications prescription or nonprescription) you are currently taking:

_____
_____
_____

Date of your most recent Tetanus shot: _____

List any muscle injuries you have had: _____

List any bone or joint injuries you have experienced: _____

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

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 requirements are specific for the country of travel. Refer to JCC provided vaccination card specific for your destination.**

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

Participant's Signature: _____ Date ___/ ___ /___
MM / DD / YY