



**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

NAME OF PROGRAM: _____

Name _____
Last First Middle Initial

Date of Birth ____/____/____
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	<input type="checkbox"/>	YES	<input type="checkbox"/>
Allergies to plants, animals, or insects?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Altitude sickness?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Anaphylactic reactions?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Arthritis?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Asthma	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Bleeding disorders?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Cardiac/circulatory problems?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Chemical (drugs, alcohol, etc.) abuse or dependency?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Diabetes?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Eating disorders (including anorexia and/or bulimia)?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Endocrine problems?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Epilepsy?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Frostbite or abnormal intolerance to cold temperatures?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Gastrointestinal problems?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Heat exhaustion/heat stroke or abnormal intolerance to hot temperatures?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
High Blood Pressure	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Hypoglycemia	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Hypertension?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Liver dysfunction?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Lymphatic problems?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Menstrual cramps? Do we really need to know this?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Muscular problems?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Neurological problems?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Premenstrual syndrome? Ditto?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Psychiatric treatment or psychological counseling?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Reproductive organ problems?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Respiratory problems including, but not limited to, asthma, chronic bronchitis or allergies?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Thyroid problems including allergy to iodine?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Are you currently under the care of a doctor or health specialist?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Do you have any dietary restrictions?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>
Do you wear contact lenses?	NO	<input type="checkbox"/>	YES	<input type="checkbox"/>

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