Medical Information Form

The information provided on this form will be held in the strictest confidence and will not be seen by any person or agency (except the trip leader) except in the event of a medical emergency. The form must be completed by all UW-Platteville students, faculty/staff participating in a university sponsored overnight fieldtrip. No later than one week after the trip is over, the Medical Information Form must be returned to each trip participant. If this is not possible or if the participant does not wish to receive the form, then the faculty/staff must immediately destroy the form.

Name of Trip Participant:____

Gender: ___________ **Date of Birth:** _________________________

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Name of personal physician: ____

Address of personal physician: ____

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Phone number of personal physician: _________________________________

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In case of emergency, contact: ____

Relationship of contact person: _____________________________

Address of contact person: ____

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Phone number of contact person: _______________________________

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Health Insurance Company: ____

Health Insurance Group Number: ____________________ **Subscriber Number:** _________________________

Health Insurance Company Address: ____

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Health Insurance Company Phone Number: ____

1. **Do you have any medical condition that you have received professional medical attention for in the past two years? If so, please describe.**

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2. **Has a physician ever denied or restricted your participation in physical activity for any medical reason? If so, please describe.**

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3. **Please list <u>all</u> prescription medications you are taking. Please include the dosage if you know it.**

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4. **Please list all over-the-counter medications that you regularly take. Please include the dosage if you know it.**

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5. **Are you allergic to any medications? If yes, please list the medications and what allergic response you experience after taking the medication.**

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6. **Have you ever had a seizure?**

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7. Have you ever blacked out? If so, what were the circumstances?

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8. Do you have asthma? If so, how serious are attacks that are triggered by exercise?

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9. List <u>all</u> allergies that you have:

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10. If you are allergic to bee/insect stings, may a bee sting kit be used in case of anaphylactic shock?

________ Yes ________ No _________ NA

11. Are you susceptible to problems associated with excessive heat? If yes, please describe these problems.

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12. What was the date of your last tetanus shot? ____

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I, the undersigned, do hereby authorize officials of the University of Wisconsin-Platteville to contact directly the persons named on this form and do authorize these officials to contact the named physician(s) to render such treatment as may be deemed necessary in an emergency for the health of the person whose name is signed below. In the event that physicians or other persons named on this form cannot be contacted, or if distance or circumstances makes it impractical for such persons to render direct medical assistance, the university officials are hereby authorized to take whatever action is deemed necessary in their judgement for the health of the undersigned. This may include, but is not limited to, taking the undersigned to a hospital for treatment or making arrangements for the undersigned to leave the trip for the purpose of returning to their primary physician(s) for treatment. In all such cases the undersigned or their parents/guardians/ insurance company are financially responsible for all medical treatment and transportation made in order to receive medical treatment. This form will be keep confidential from all persons at all times except the trip leader who will hold this form. I understand that this form will be shared with appropriate medical personnel in case of any medical situation which requires medical treatment.

____ ______________________________________

Signature of Trip Participant Date of Signature