



COTTONWOOD INSTITUTE

"Changing the world, one adventure at a time!"

PO Box 7067, Denver, Colorado 80207

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MEDICAL AND HEALTH HISTORY FORM

Participant Name	Program/Course Number	Date of Birth	Age	Height	Weight

Please check the following boxes if the student has any of the following problems:

- | | | |
|--|--|--|
| <input type="checkbox"/> Head injuries | <input type="checkbox"/> Asthma or respiratory problems | <input type="checkbox"/> Dehydration |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Smoker | <input type="checkbox"/> Psychological illnesses |
| <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Abdominal/internal organ problems | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Altitude sickness | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Skin problems or reactions | <input type="checkbox"/> Urinary tract infections |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Frostbite or hypothermia | <input type="checkbox"/> Lactose Intolerant |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Heat exhaustion or heat stroke | |
| <input type="checkbox"/> Diabetes | | <i>Female students only:</i> |
| <input type="checkbox"/> Jaundice | | <input type="checkbox"/> History of menstrual problems |
| <input type="checkbox"/> HIV/AIDS | | <input type="checkbox"/> Pregnancy |

Please list all life threatening illnesses and/or special medical concerns:

Please describe allergies to medications, foods, insects, pollens, etc.	Severity (High/Low)

List all prescriptions and/or over-the-counter medications	Frequency and dosage of medication	Reason for use	Known/Potential side-effects

Please list all dietary restrictions and concerns:

Please include any additional information that would help us ensure the safety of your son/daughter in the backcountry:

INSURANCE/PHYSICIAN INFORMATION

Do you have medical insurance?	Medical Insurance Carrier	Policy #	Insurance Phone #
Primary Physician Name	Primary Physician Phone #	Secondary Physician Name	Secondary Physician Phone #

EMERGENCY CONTACT INFORMATION

Emergency Contact Name #1	Relationship to Participant	Home Phone	Work/Cell Phone	Email Address
Emergency Contact Name #2	Relationship to Participant	Home Phone	Work/Cell Phone	Email Address

- By signing below, I/we attest that the information on this Medical Health History Form is correct to the best of my/our knowledge.
- In the event of an emergency, I understand that efforts will be made to secure proper treatment. I hereby authorize and give permission for the Cottonwood Institute to obtain transportation for me/my child to a medical facility, to secure proper treatment for, order routine tests and treatment for, or to hospitalize me/my child in the event that I/we cannot give consent.
- I/we understand that the Cottonwood Institute and its officers, directors, Instructors, staff, volunteers, medical advisor, sub contractors, independent contractors, or agents are not responsible for administering prescription or over-the-counter medications to participants or volunteers.
- The undersigned hereby agrees to release the Cottonwood Institute and its officers, directors, Instructors, staff, volunteers, medical advisor, sub contractors, independent contractors, or agents from any legal claim(s) which they now have or may hereafter have arising out of the administration of (or failure to administer) the above mentioned prescribed or over-the-counter medication(s) to the participant.
- I/we give permission to discuss my/my child's medical history and information presented on this Medical and Health History Form with my/my child's Physician, Health-Care Practitioner, and Cottonwood Institute Staff.

Signature of Participant/Volunteer Signature: _____ Date: _____ Print Name Here: _____

Signature of Parent or Guardian: (If participant is under 18 yrs. old) _____ Date: _____ Print Name Here: _____