Outpost Wilderness Adventure

20859 CR 77 Lake George, CO 80827 719-748-3080

Health Form

This side to be filled in by parent or adult client and checked with physician at time of examination.

Name _____ Birth Date _____ Sex _____ Age _____
Last First Initial

Parent or Guardian (Spouse or nearest relative if over 18) _____ Phone _____

Home Address _____ City _____ State _____ Zip _____
Parent Business Address _____ City _____ State _____ Zip _____
If not available in an emergency notify:

1. Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____

HEALTH HISTORY: (Check-giving approximate dates)

	Allergies	Diseases
____ Ear Infections	____ Hay Fever	____ Chicken Pox
____ Rheumatic Fever	____ Ivy Poisoning, Etc	____ Measles
____ Convulsions	____ Insect Stings	____ German Measles
____ Diabetes	____ Penicillin	____ Mumps
____ Behavior	____ Other Drugs	____ Asthma

Operations or serious injuries (Dates) _____

Chronic or recurring illness _____

Has this person received counseling or therapy for emotional or mental concerns? _____

Any specific activities to be encouraged? _____

Any activities to be restricted? _____

IMPORTANT: ***This entire health form is important. Failure to complete all portions could result in an injury or compound the damage from an injury. Please notify OWA if this individual is exposed to any communicable disease during the 3 weeks prior to attendance in any OWA event.***

Suggestions from Parents:

_____

_____

_____

NOTE*****VERY IMPORTANT!

Medical Release and Authorization

This health history is correct so far as I know, and the person herein named has permission to engage in all OWA activities except as noted by the examining physician.

If medical treatment is necessary, I hereby give permission to the OWA Director or the Team Leader in charge to secure proper medical treatment, which may include but not be limited to, hospitalization, surgery, ordering of injection, anaesthesia, for the person named above.

Signed: _____
Parent or guardian if under 18

Dated: _____

IMMUNIZATION HISTORY

Required immunizations must be determined locally. This is a record of dates of basic immunizations and most recent booster doses.

DTP Series _____ Booster _____ Tetanus Booster _____

Polio OPV (Sabin) _____ Booster _____ Typhoid _____

Measles Vaccine (live) _____ Tuberculin Test _____

German Measles (Rubella) _____ Mumps Vaccine (live) _____

Smallpox _____ Hep A _____ Hep B _____

MEDICAL EXAMINATION-- *To be filled out by licensed physician.*

This examination should be performed within 1 year of participation in the OWA expedition, trip, camp or other event. Examination for some other purposes within this period is acceptable. Examination is for determining fitness to engage in strenuous activities.

Code: **OK** --Satisfactory **X**-- Not Satisfactory (explain) **N/A**-- Not Determined

Height _____ Weight _____ B.P. _____ Urinalysis _____

Pulse _____ Respirations _____

Eyes _____ Glasses _____ Extremities _____

Posture (spine) _____ Ears _____ Skin _____

Nose _____ Throat _____ Teeth _____

Allergy (Please Specify) _____ Abdomen _____

Heart _____ Lungs _____ Hernia _____

General Appraisal: _____

(For Females)

Has this person menstruated? _____ If not, has she been told about it? _____

If so, is her menstrual history normal? _____ Special Considerations:

Recommendations and restrictions while participating in an OWA program:

Special Diet _____

Special Medicine (name it) _____ Is parent sending it? _____

Swimming _____ Strenuous Activity _____

Other _____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically able to engage in OWA camp, program, expedition, and event activities, except as noted above.

Examining Physician: _____ **M.D.**

Phone _____ Address _____

Date _____