**RMPE**

**Today’s Date:**

**\_\_\_\_\_\_\_\_\_\_**

**Extended Trip Medical Form**

**Outing Date & Title**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **PARTICIPANT CONTACT INFORMATION** |
| LAST NAME | FIRST NAME |
| LOCAL PHONE # | ASU BOX | ASU EMAIL |
| LOCAL ADDRESS |
| BIRTH DATE | HEIGHT | WEIGHT |
| NAME OF PERSON TO CONTACT IN CASE OF AN EMERGENCY |
| EMERGENCY CONTACT PHONE # |

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| HEALTH STATEMENT (Provision of this Information is Voluntary) |
| *This outing may involve participation in outdoor activities which are, by their nature, physically demanding. Therefore, all participants are encouraged indicate any medical or physical conditions that might create special considerations for themselves and others. Furthermore, medical care may be many hours away in case of an emergency. Physical strength is not required; although being in good condition will increase your enjoyment of the outing activities. If there is any doubt about your ability to safely participate in the outing activities, you should consult your physician and then notify the Recreation Management professor in charge of this activity as to advice and recommendations.* |
| What physical conditions or restrictions do you have which may limit your participation in this activity? |
| Are you taking any medications? If so, what type? |
| Do you have any allergies/reactions to the following?  Yes (Please indicate below)  No |
|   Dust |  Other Medication |  Food: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|   Penicillin |  Insects (bees, etc.) |  Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Please describe any additional allergies/reactions to medications that we should know about: |
| Water-based Programs: (Please check one.)  Good Swimmer  Can Swim  Non-Swimmer |
| I understand the nature of the physical demands of this activity. I have noted about any medical or physical conditions I have which might affect my participation. I therefore release any and all claims for damages against Appalachian State University, and all individuals instructing and conducting these activities, for any and all injuries, loss or damage suffered by me during, or in any way connected with these activities. |
| PARTICIPANT SIGNATURE DATE: |
| PARETN OR GUARDIAN SIGNATURE IF PARTICIPANT IS UNDER 18 DATE: |

The information provided on this medical form is confidential and is used only by the department to make your experiences as safe and enjoyable as possible. Individuals with disabilities requiring accommodation must register with ASU's Office of Disability Services ("ODS"), and must have ODS advise the instructor as to the nature of the appropriate accommodations.