Participant Medical Record

To be completed by the applicant.
Applicants are strongly encouraged to review this questionnaire with their primary physician.

For office use only.
Rec'd _____
Approval _____

PART 1: APPLICANT GENERAL INFORMATION

Participant

Name _____
Gender _____
Age at Course Start _____ D.O.B. ___/___/_____
Daytime Telephone _____
Evening Telephone _____
Cell Phone _____
Fax _____
Email _____

Parent/Guardian 1

Name _____
Relationship _____
Address _____
City/State/Zip _____
Occupation _____
Phone _____
Alternative Phone _____
Email _____

Parent/Guardian 2

Name _____
Relationship _____
Address _____
City/State/Zip _____
Occupation _____
Phone _____
Alternative Phone _____
Email _____

Emergency Contact *(not parent/guardian)*

Name _____
Relationship _____
Cell Phone _____
Alternative Phone _____

Family Physician

Name _____
Phone _____
Fax _____
Email _____

Insurance information

Each participant is responsible for any medical expenses and should by covered by his/her own illness and accident insurance.
Please attach a photocopy of both the front and back of your insurance card.

These questions must be answered for our record.

Do you have insurance? _ Yes _ No
Insurance Company _____
Policy/Certificate # _____
Prescription Plan # _____
Phone _____

Signature Required
Consent is hereby given for the applicant to attend a College of the Atlantic (COA) program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment which may become necessary. All information will remain confidential. You should know that over the years, many students with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow students.

If you arrive at the start of a program with a pre-existing condition or injury which has not been indicated on your medical form and you are subsequently forced to leave the program because of that condition, you will be charged an evacuation fee and will not receive a refund.

Participant's Signature _____ Date _____/_____/_____

Parent or Guardian's Signature _____ Date _____/_____/_____

Participant Name _____

PART 2: APPLICANT HISTORY OF PAST AND PRESENT MEDICAL CONDITIONS

A. Conditions and Symptoms (please fill in every blank)

	Y / N							
1		High Blood Pressure	24		Frostbite	47		Ankle Problems
2		Heart Diease	25		Circulation Problems	48		Leg Problems
3		Heart Murmur	26		Bed-wetting	49		Feet Problems
4		Irregular Heart beat	27		Headaches	50		Currently Pregnant
5		Family History of Heart Diease	28		Head Injury	51		Medical Equipment
6		Tuberculosis	29		Stomach Ulcers	52		Learning Disability
7		Recent Exposure to TB	30		Intestinal Problems	53		Special Diet
8		Positive TB Test	31		Heatstroke	54		Unexpected Weight Loss
9		Active Hepatitis	32		Bladder Infection	55		Other
10		History of Hepatitis	33		Difficulty Urinating	Do you currently or regularly have any of the following symptoms?		
11		Seizure Disorder/Epilepsy	34		Kidney Problems			
12		Seizure within past year	35		Thyroid Problems	56		Chest Pain/ Pressure
13		Bleeding Disorder	36		Endocrine Problems	57		Heart Palpitations
14		Blood Disorder/ Anemia /Sickle Cell Trait	37		Hearing Problems	58		Intolerance to Warm or Cold Temperatures
15		Chronic Cough	38		Vision Impairment	59		Unexplained Sweating
16		Recurrent Lung Infections	39		Motion Sickness	60		Frequent Dizziness
17		Asthma	40		Sleep Walking	61		Frequent Fainting
18		Diabetes	41		Broken Bones	62		Heartburn
19		Hypoglycemia (blood sugar)	42		Neck Problems	63		Muscle Cramps
20		Anorexia Nervosa	43		Back Problems	64		Frequent Shortness of Breath
21		Bulimia	44		Arm Problems	65		PMS/ Menstrual Problems
22		Cancer	45		Shoulder Problems	66		Other
23		Skin Problem	46		Knee Problems			

If you have answered "yes" to any of the above items, or have a condition that does not appear on this list, please use the bottom and the back of this page to explain. Please include the following:

- Specific symptoms that are occurring
- How often symptoms/condition occurs
- How symptom/condition restricts your activity in any way, including your ability to run, lift, and climb
- How long your symptom/condition lasts
- Date of your last occurrence
- How you care for the symptom/condition

Do you menstruate? yes no

Participant Name _____

B. Allergies (including allergies to medicines, foods, insect bites/stings, etc.)

Please check here _____ if applicant has no known allergies

Allergy (list below)	Reaction(s)	Medication Required (if any)

Note: If you experience systemic allergic reactions that require the use of an EPI-pen or ANA-Kit, please consult your physician about bringing two doses with you on a trip; one dose will be held by a trip leader in the First-Aid kit.

C. Medications You are Currently Taking *(if psychiatric medication, please list any taken within the past two months)*

Please check here _____ if applicant has no medications

Medication (list below)	Taken for (Symptom/Condition)	Dosage (size/frequency)	Date Started	Current Side Effects (if any)

Note: If you are on a trip and currently taking a medication, bring double amounts in separate, non-breakable, waterproof containers, along with the dosage instructions; one dose will be held by the trip leader in the First-Aid kit.

D. Immunization and Physicals

College of the Atlantic recommends all participants have a current tetanus immunization (within 10 years).
Please contact the Registrar's Office for a list of all required immunizations. College of the Atlantic does not require physicals.

E. Blood Pressure (must be taken within 6 months of course start)

Blood Pressure ___/___ Date ___/___/___

If BP is over 150/90, please take a second reading: Blood Pressure ____/____ Date ____/____/____

F. Hospitalizations/Emergencies/Urgent Care

Please check here _____ if applicant has not been hospitalized, had an health emergency or received urgent care within the past two years

Date of Visit/Admittance	Reason	Length of Stay

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Participant Name _____

G. Personal/Counseling History (please answer with regards to the past two years)

	Y	N
Have you been in counseling with a psychiatrist, psychologist, guidance counselor, or other counselor?	_	_
Are you currently in counseling or treatment with a counselor, psychiatrist, psychologist, or prescribing physician?	_	_
Have you arranged a release of information with your counselor and/or prescribing physician so we may contact them for further information? (This would be used to define your ability to participate in COA sponsored trips.)	_	_

Please check the appropriate responses that indicate the reason(s) for counseling:

_ Academic/Career _ Divorce _ Family Issues _ Maintenance of Medication

_ Substance Abuse _ Depression _ Eating Disorder _ Suicidality

_ Bereavement/Grief _ Other (Please Explain)

Name of current (or most recent) counselor_____

Telephone _____ Fax _____ Email _____

Please use the following spaces to list any psychological problems that are current or ongoing.

_____

_____

_____

H. Life Style and Trip Expectations

In order to contribute to a safe, inclusive group experience, all College of the Atlantic trips are substance-free (including tobacco). In the event that a participant is found to be using alcohol or other drugs (whether of legal age or not), they may be immediately removed from a trip and processed through the college's Judicial Hearing process. If you are unsure you can go through an experience substance-free, please think seriously about not registering for the experience.

I. Current Exercise Activity and Physical Limitations (needed as important trip assessment tool)

Please list the activities you engage in daily or weekly which indicate your current fitness level. Be sure to include activities such as walking a pet, mowing the lawn, or after school activities like playing basketball or skateboarding.

Activity (list below)	Frequency	Approximate time/distance

Please use the back of this page to disclose any physical limitations you may have.

Note: You will be expected to engage in rigorous physical activity during your COA OOPs experience. It is vital that you start (or continue) a conditioning regimen in preparation for the program.

J. Swimming Ability (please check one): _ Non-Swimmer _ Cannot swim more than 100 yards _ Moderate Swimmer _ Strong Swimmer _ Current Lifesaving Certificate

K. Food Preferences (please check one): _ Vegan _ Vegetarian _ Omnivore

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Release & Indemnification of all Claims

Please complete this form and return it with your OOPs Registration and Medical Form. (Due June 1)

THIS DOCUMENT WILL AFFECT YOUR LEGAL RIGHTS. PLEASE READ CAREFULLY.

I agree that my participation on this Outdoor Program trip (OOPs) on August **29 through September 3, 2022,** is entirely voluntary; in the event of unsuitable weather, the trip will take place the next day. That in consideration for participation, I agree, on behalf of myself, my assigns, executors, and heirs, to release, indemnify and hold harmless College of the Atlantic, its trustees, officers, agents, employees, and the trip leaders, from any cause or action, claims or demands of any nature whatsoever, including but not limited to a claim of negligence, which I, my heirs, representatives, and executors may now have, or have in the future, against the college, on account of personal injury, property damage, death or accident of any kind arising out of or in any way related to my participation on this trip including any act or omission of any third party (rescue squad, hospital, etc.).

I understand and hereby agree that I am financially responsible for all expenses related to any emergency and rescue care that results from my own, independent decision-making, contrary to the instructions, explicit or otherwise, of my trip leaders or the conditions laid out below.

I understand that all participants are subject to COA regulations, the laws of the State of Maine, and the laws of the United States, and that in the event of violation of these or behavior which is considered by the trip leader and/or the Dean of Student Life to be detrimental to the participant, to the other participants, or to the college, the leaders shall have the right to dismiss the participant from the trip while retaining all payments.

I have read and understand the terms of this agreement and release and agree to all terms and conditions on behalf of myself and my heirs, and my heir's representatives. I hereby certify by my signature that I am physically fit and able to participate in the field trip. Consistent herewith, I assume responsibility for my own physical fitness and capability to participate in the trip and have taken such steps as I deem appropriate to assure myself that I am fit and capable of such participation.

I further state that I am cognizant of all the inherent dangers of participation and risks involved in the wilderness experience which include but are not limited to drowning, rock fall, lightning, environmental injuries, road crossings, wildlife attacks, sprained ankles, broken legs, etc.. I understand that I may be a long distance from medical facilities.

I certify that I am of lawful age or my parent or guardian is of lawful age and legally competent to sign this affirmation and release; that I understand the terms herein are contractual and not mere recital, and that I have signed this document as my own free act.

Participant's Signature _____ Date _____/_____/_____

Participant's Name _____ Date of Birth _____/_____/_____

Parent or Guardian's Signature _____ Date _____/_____/_____

Parent or Guardian's Name _____

Updated January 2022