

# GriefRites 2008

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## MEDICAL FORM

**THIS FORM MUST BE FILLED OUT ACCURATELY AND COMPLETELY BY PARTICIPANT AND, IF 18 OR UNDER, PARENT OR GUARDIAN.**

Please note:

- Filling out this medical form honestly and completely is the first step in taking care of yourself on the course. For your safety, it is important that we know as much as we can about your physical condition. Many medical conditions will not prevent you from successfully completing the course, but failure to disclose information could result in serious harm to yourself or other participants.
- Every item on this form must be completed. If it does not apply to you, mark "N/A"
- If you have certain medical conditions, we may require that you have a physician fill out a supplemental form.
- All information you provide will remain confidential.

### PART I. GENERAL INFORMATION.

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age at Course Start \_\_\_\_\_

Address \_\_\_\_\_ City/State/ZIP \_\_\_\_\_

Phone \_( ) \_\_\_\_\_ Email \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_( ) \_\_\_\_\_

*In Case of Emergency Contact* \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Daytime Phone \_( ) \_\_\_\_\_ Evening Phone \_( ) \_\_\_\_\_

**PLEASE NOTE: Each participant is responsible for any medical expenses for illness or injury occurring during or as a result of participation in the course, and should be covered by their own insurance.**

Are you covered by any hospitalization and medical care policy? Yes No

Insurance Company Name \_\_\_\_\_

Policy or Certificate # \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

Does the insurance company require pre-authorization? Yes No

If yes, please give phone # \_\_\_\_\_

## **PART II. PARTICIPANT HISTORY: PAST AND PRESENT MEDICAL PROBLEMS**

(To be completed by applicant. Use additional pages if necessary.)

### **A. Conditions and Symptoms**

Do you have, or have you had, any of the following conditions or symptoms? Please circle any and all that apply.

- |   |  |   |
|---|--|---|
| 1. High Blood Pressure                      | 23. Skin Problem                           | 46. Ankle problem   |
| 2. Heart Disease                            | 24. Frostbite                              | 47. Leg problem   |
| 3. Heart Murmur                             | 25. Circulation problems                   | 48. Foot problem  |
| 4. Irregular Heartbeat                      | 26. Acute bedwetting                       | 49. Currently pregnant  |
| 5. Family history of heart attack           | 27. Head injury w/ neurological impairment | 50. Special diet  |
| 6. Tuberculosis                             | 28. Stomach ulcers                         | 51. Learning disability   |
| 7. Recent exposure to active TB             | 29. Intestinal problems                    | 52. Medical equipment/Devices                                     |
| 8. Positive TB test                         | 30. Heatstroke                             | 53. Unexplained weight loss                                       |
| 9. Active Hepatitis                         | 31. Bladder infection                      | 54. Other _____   |
| 10. History of Hepatitis                    | 32. Difficulty urinating                   | Do you currently or regularly have any of the following symptoms? |
| 11. Seizure Disorder                        | 33. Kidney problems                        | 55. Chest pain/pressure   |
| 12. Seizure within past year                | 34. Thyroid problems                       | 56. Heart palpitations  |
| 13. Bleeding Disorder                       | 35. Endocrine problems                     | 57. Unexplained sweating  |
| 14. Blood disorder/anemia/sickle cell trait | 36. Hearing impairment                     | 58. Frequent shortness of breath                                  |
| 15. Chronic cough                           | 37. Vision impairment                      | 59. Frequent dizziness  |
| 16. Recurrent lung infections               | 38. Motion sickness                        | 60. Frequent fainting   |
| 17. Asthma                                  | 39. Sleep walking                          | 61. Heartburn   |
| 18. Diabetes                                | 40. Broken bones                           | 62. Muscle cramps   |
| 19. Hypoglycemia                            | 41. Neck problem                           | 63. Intolerance to warm temps.                                    |
| 20. Anorexia Nervosa                        | 42. Back problem                           | 64. Intolerance to cold temps.                                    |
| 21. Bulimia                                 | 43. Arm problem                            | 65. PMS or menstrual problems                                     |
| 22. Cancer                                  | 44. Shoulder problem                       | 66. Other _____   |
|   | 45. Knee problem                           |   |



**C. Medications**

List any medications you are taking, including psychiatric and over-the-counter medications.

<b>Medication</b>	<b>Condition</b>	<b>Dosage (amt. and frequency)</b>	<b>Current Side Effects</b>

*Note: If you are currently taking medication, bring double amounts in separate, non-breakable, waterproof containers, along with dosage instructions.*

**D. Required Immunization**

<b>Immunization</b>	<b>Requirement</b>	<b>Year of Last Immunization</b>
Tetanus	Within 10 years of course start	

**E. Hospitalizations and Emergencies**

Please list any hospital or emergency room visits in the past two years.

<b>Dates</b>	<b>Reason</b>	<b>Length of Stay</b>

**F. Personal History**

- 1. Have you been in counseling with a psychiatrist, psychologist, or other counselor within the past two years? \_\_\_\_\_
- 2. Are you currently in counseling or treatment? \_\_\_\_\_
- 3. If not currently in treatment, when was counseling terminated? \_\_\_\_\_
- 4. Reason for counseling \_\_\_\_\_

**G. Lifestyle**

- 1. Do you use alcohol? \_\_\_\_\_ How much and how often? \_\_\_\_\_
- 2. Do you use tobacco? \_\_\_\_\_ How much and how often? \_\_\_\_\_
- 3. Do you use any kind of recreational drugs? \_\_\_\_\_ What kind? \_\_\_\_\_  
How much and how often? \_\_\_\_\_
- 4. Do you have a history of substance abuse or chemical dependency? \_\_\_\_\_  
Drugs used \_\_\_\_\_ Date last used? \_\_\_\_\_

**H. Current Exercise and Fitness Level**

1. Please list your current exercise activity.

Activity	Frequency	Approx. Time/Distance	Leisurely	Moderate	Intensely

*Note: You don't have to be an athlete or extremely fit to go on a HealingQuest course, but prior conditioning will make the physical aspect of your course more enjoyable.*

3. Height \_\_\_\_\_ Resting Pulse \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Weight \_\_\_\_\_

**I. Additional Comments**

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## **J. Signature Required**

I understand that HealingQuest courses are physically and mentally strenuous experiences that take place in a remote wilderness area, far from conventional medical facilities. The information on the preceding pages is a complete and accurate statement of my past and present medical condition, and I have included all physical and psychological factors that may affect my participation in a HealingQuest course. I realize that failure to disclose such information could result in serious harm to myself and/or fellow participants. I agree to indemnify and hold HealingQuest harmless if all relevant information is not disclosed. I agree to notify HealingQuest should there be any change in my health status prior to my course start.

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Participant's Signature

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Date