Weber State University, Outdoor Program
Medical Questionnaire and Disclosure Agreement

In consideration of my participation in _____ (hereafter referred to as "activity") with Weber State University Outdoor Program (hereafter, "OP"), I offer the following information on my current medical condition:

Participant Information

Full Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Health Insurance Provider: _____
Policy, Contract, and/or Group Number: _____
Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Emergency Contact Information

Full Name of Contact: _____
Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Day Phone: _____ Evening Phone: _____ Other Phone: _____
Email Address: _____

The following description of conditions are designed to help you determine if you are physically and mentally fit to participate in Weber State University's Outdoor Program, in consultation with your physician. In addition, you should review all the risks of the specific activity in which you desire to engage and consult your physician. Responses are voluntary. Disclosure may assist the Outdoor Program in the event of an emergency, but you acknowledge and affirm it is your responsibility, together with your physician, to determine if you are in a condition to participate in Outdoor Program activities. You agree that you are ultimately responsible for that decision.

Do you have a history of or currently have any of the following? Check appropriate boxes below:

□ No □ Yes Heart attack, heart disease, heart palpitations/murmur
□ No □ Yes Hypertension
□ No □ Yes Chest pain/pressure, angina
□ No □ Yes Stroke
□ No □ Yes Smoking
□ No □ Yes Diabetes
□ No □ Yes Epilepsy, seizures, or neurologic concerns
□ No □ Yes Mental health concerns
□ No □ Yes Gastrointestinal concerns
□ No □ Yes Genitourinary concerns
□ No □ Yes Asthma or other respiratory concerns
□ No □ Yes Musculoskeletal injury
□ No □ Yes Infectious disease or blood-borne pathogen
□ No □ Yes Dietary restrictions
□ No □ Yes Allergies (insects, foods, drugs)
□ No □ Yes Frostbite, cold injury, or Raynaud's Syndrome
□ No □ Yes Heat illness

□ No □ Yes Altitude illness
□ No □ Yes Pregnancy
□ No □ Yes Recent injury/illness
□ No □ Yes Corrective lenses

If you answered "yes" to any of the foregoing questions, describe below (attach additional pages if necessary):

If you answered "yes" to allergies or asthma, are you currently carrying epinephrine (Epi-Pen) or albuterol (rescue inhaler), respectively?

Are you currently taking any medications? If so, please list medication and dosing below:

Are you currently under the care of a medical professional? If so, please describe:

Are there any other medical concerns that you or your physician feel may affect your participation in this activity of which you feel OP staff should be aware? If so, please describe below:

To the best of my knowledge, the preceding information is an accurate representation of my pertinent medical history. I declare that I am in good physical health and believe that I am able without reservation or limitation to cope physically with the rigors of this activity. In the event of an emergency, I grant permission for any evacuation, transportation, medical intervention, and/or care that may be necessary for my immediate well-being. I further authorize the release of any relevant medical information to any medical facility or personnel as necessary to my immediate well-being.

Signature Date