

# NOAH'S ARK ADVENTURE PROGRAM, LTD.

## Health History / Consent Form

### INTRODUCTION / INSTRUCTIONS:

**To Parent/Guardian/Participant:** We desire every participant at Noah's Ark to have a successful experience. However, in the event of an accident occurring we need certain information to be available. When you or your child attends Noah's Ark, the following information is needed: 1) Medical history and 2) Medical insurance information. Parent/Guardian/Participant is to complete SECTIONS 1, 2, and 3. **It is strongly recommended that a physician complete SECTION 4 if any conditions have been indicated in SECTION 2.**

**Diabetes:** Insulin-dependent diabetics should bring two times the regular supply of treatment materials needed for the duration of their stay at Noah's Ark. Diet and physical exertion may require the alteration of regular treatment methods. Diabetics who have been diagnosed in the last 12 months, who have experienced a hypoglycemic crash or instability within the last 6 months, whose condition is incompletely controlled, or who have changed method of intake (i.e. insulin pump) in the past 6 months will not be allowed to participate in a wilderness experience at Noah's Ark.

**Asthma:** Participants with asthma should be able to control their condition restoring normal lung function. Bronchodilators must be brought by asthmatic individuals and carried with them at all times on all activities engaged in at Noah's Ark; also, twice the normal amount of medication should be brought. Asthmatic individuals who have been hospitalized in the past 6 months or who have experienced anaphylactic symptoms (e.g. difficulty breathing, low blood pressure, facial changes such as tongue swelling) will not be allowed to participate in wilderness activities at Noah's Ark.

Do you have previous whitewater rafting experience? Check one:  YES  NO

### SECTION 1 – Identification, Emergency Contact

Group Name: \_\_\_\_\_ Group Leader \_\_\_\_\_ Date of Trip: \_\_\_\_\_

Participant Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Name of Dentist/Orthodontist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

#### In Case of Emergency Notify:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_

Phones: (Home) \_\_\_\_\_ (work) \_\_\_\_\_ (fax) \_\_\_\_\_  
(mobile) \_\_\_\_\_ (alternative phone) \_\_\_\_\_

Alternate Contact 1: \_\_\_\_\_ Relationship: \_\_\_\_\_ (phones) \_\_\_\_\_

Alternate Contact 2: \_\_\_\_\_ Relationship: \_\_\_\_\_ (phones) \_\_\_\_\_

### SECTION 2 – Health History

Are you now or have you ever been treated for any of the following? If yes, check box, give date and provide specific details below:

Condition	Date	Condition	Date	Condition	Date
<input type="checkbox"/> Bleeding Disorders	_____	<input type="checkbox"/> Fainting Spells	_____	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Clotting Disorders	_____	<input type="checkbox"/> Abdominal Problems	_____	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> Seizures	_____	<input type="checkbox"/> Heart Trouble/Disease	_____	<input type="checkbox"/> Surgeries	_____
<input type="checkbox"/> Hypertension	_____	<input type="checkbox"/> Mental Problems	_____	<input type="checkbox"/> Sickle Cell Anemia	_____
<input type="checkbox"/> Eating Disorders	_____	<input type="checkbox"/> Emotional Distress	_____	<input type="checkbox"/> Other _____	_____

**If you have checked any of the above boxes or are concerned about your medical, physical, or emotional well being, we strongly suggest you consult a physician (Section 4) before attending. It is your responsibility to determine if you are able to undertake these activities.**

(Use additional paper and attach if necessary)

Specific and full details on any conditions above: \_\_\_\_\_

Allergies to any medications: \_\_\_\_\_

Allergies to food, insect bites, plants, other: \_\_\_\_\_

Have you had more than a brief minor illness (24 hours or more) or injury during the past year? If so, what and when? \_\_\_\_\_

Serious injuries (dislocations, fractures, strains, sprains) or hospitalizations to date, any reason (date/detail): \_\_\_\_\_

Any loss of consciousness, traumatic or otherwise (date/detail): \_\_\_\_\_

Serious operations to date (date/detail): \_\_\_\_\_

Chronic or recurring illness, including mental illness (date/detail): \_\_\_\_\_

All medications prescribed and over-the-counter currently taken (include dosage): \_\_\_\_\_

Dietary restrictions: \_\_\_\_\_

Restricted activities (detail): \_\_\_\_\_

**SECTION 3 – Authorization for Participation from Parent/Guardian/Participant**

Has it ever been necessary to restrict participant’s activities due to medical reasons? \_\_\_ Yes \_\_\_ No Does participant take medicine regularly or have special care? \_\_\_ Yes \_\_\_ No If YES, explain: \_\_\_\_\_

The health history is correct so far as I know, and the person herein named has permission to engage in all activities unless specified under “Restricted Activities”. I testify that my child is of good physical and mental health and is capable of participation in the activities for which he has applied, which may include whitewater rafting, rock climbing, hiking, ropes course, backpacking, canoeing, rappelling or mountain climbing.

I hereby give permission for transportation to any medical facility or hospital and I authorize any guide or medical personnel to render emergency medical care for my family or myself. I hereby authorize the release of any medical information in the possession of *Noah’s Ark Whitewater Rafting Co. and Adventure Program Ltd.* to any medical facility, hospital, ambulance, first aid provider, first aid service, doctor, nurse or other such person rendering care on my behalf. I hereby waive any action or claim against *Noah’s Ark Whitewater Rafting Co. and Adventure Program Ltd.* or any health care provider, hospital, doctor, nurse or first aid provider for the release of this medical information.

I understand that *Noah’s Ark Whitewater Rafting Co. and Adventure Program, Ltd.* does not provide accident insurance. I understand that it is suggested that I check my insurance policy to make sure accidents occurring on trips with *Noah’s Ark Whitewater Rafting Co. and Adventure Program, Ltd.* are covered by my insurance.

I further understand that *Noah’s Ark Whitewater Rafting Co. and Adventure Program Ltd.* reserves the right to refuse any person it judges to be incapable of meeting the rigors and requirements of any activity for any reason.

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

2<sup>nd</sup> Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

**SECTION 4 – Physician’s Evaluation (recommend to be completed if conditions named in Section 2 were indicated)**

**To Physician:** Participants at Noah’s Ark will engage in strenuous activities during their stay. These can include, but are not limited to, rock climbing, rappelling, ropes course, whitewater rafting, and hiking or backpacking. Backpacking can involve hiking 2-8 miles a day and carrying a 30-50 pound pack in rugged wilderness terrain ranging from 8,000 to over 14,000 feet in elevation.

Please complete the following:

_____ Height	_____ Weight* <small>*suitable for activities</small>	_____ BP	_____ Pulse
Does the participant have epilepsy? ___ Yes ___ No		Does the participant have diabetes? ___ Yes ___ No	
Does the participant have asthma? ___ Yes ___ No		If yes, is diabetes under control? ___ Yes ___ No	

Recommendations (explain any restrictions OR limitations): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Any allergies? \_\_\_\_\_

Any treatment and/or medication to be continued while at Noah’s Ark? \_\_\_\_\_

Any medically prescribed meal plan or dietary restriction? \_\_\_\_\_

Additional health information \_\_\_\_\_  
 \_\_\_\_\_

In my opinion, the condition of the named participant does not preclude his/her participation in the adventure activities at Noah’s Ark.

Physician’s Name: \_\_\_\_\_

Physician’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of form completion: \_\_\_\_\_ By \* \_\_\_\_\_  
\*if form is completed by nurse or physician assistant