

NOAH'S ARK ADVENTURE PROGRAM, LTD.

Health History / Consent Form

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: _____

In Case of Emergency Notify:

Name: _____ Relationship: _____

Address: _____

City/State/Zip: _____

Phone: _____ Phone (alternative): _____

SECTION 2 – Health History (use additional paper if necessary)

1. Are you now or have you ever been treated for any of the following?

- | | | |
|---|--|---|
| <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 3) before attending. It is your responsibility to determine if you are able to undertake these activities.

2. If yes, please provide which condition(s), date(s), and specific details on any conditions above:

3. Allergies to medications:

4. Allergies to food, insect bites, plants, other:

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

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

7. Any loss of consciousness, traumatic or otherwise (date/detail):

8. Chronic or recurring illness, including mental illness (date/detail):

9. All medications prescribed and over-the-counter currently taken (include dosage):

10. Dietary restrictions:

11. Restricted activities (detail):

12. Have you ever experienced AMS (Acute Mountain Sickness), HAPE (High Altitude Pulmonary Edema), or HACE (High Altitude Cerebral Edema)? If so, please provide specific and full details:

SECTION 3 – 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	_____ 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):			
<hr/> <hr/>			
Any allergies:			
<hr/> <hr/>			
Any treatment and/or medication to be continued while at Noah’s Ark?			
<hr/> <hr/>			
Any medically prescribed meal plan or dietary restriction?			
<hr/> <hr/>			
Additional health information:			
<hr/> <hr/>			
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