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?

☐ Bleeding Disorders	☐ Fainting Spells	☐ Diabetes
☐ Clotting Disorders	☐ Abdominal Problems	☐ Asthma
☐ Seizures	☐ Heart Trouble/Disease	☐ Surgeries
☐ Hypertension	☐ Mental Problems	☐ Sickle Cell Anemia
☐ Eating Disorders	☐ Emotional Distress	☐ 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):

_____

_____

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