Azusa Pacific University
Outdoor Adventures
Confidential Medical History and Physical Examination Record

INSTRUCTIONS:

Applicant completes Part I.
Parent or Guardian completes and signs Part II, if applicant is under legal age (18 years)

PART I: GENERAL INFORMATION (To be completed by applicant)

1. Name _____
2. Address: Street _____ City _____ State ____ Zip _____
3. Home Telephone (___) _____ 4. Today's date: _____
5. Present Age: _____ 6. Birth date: _____ 7. Male ____ Female _____
8. Family Physician: _____ 9. Telephone: (___) _____
10. Physician's Address: _____
11. Person to be notified in case of illness or emergency:
    Name: _____ Relationship: _____
    Full Address: _____
    Home Telephone: (___) _____ Business Telephone: (___) _____

PART II: MEDICAL INSURANCE (must be completed and signed by applicant)

Students are covered by the insurance policy required of all full time and undergraduate students (7 units or more). For those who have additional coverage through their parent's insurance or any other source must complete the following:

1. Indicate name or names of additional insurance companies you are covered by:
   _____
   _____
2. Indicate Policy or Certificate number: _____
3. Address of Insurance Company office to which we could write for forms:
   _____

Consent is hereby given for the applicant to participate in the Outdoor Experience, Camping Course and receive emergency medical treatment.

X _____ Date: _____
Applicant

X _____ Date: _____
Signature of Parent/Guardian (if applicant is under 18 years of age)

X _____ Date: _____
Witness

PART III MEDICAL HISTORY

If the applicant has had any of the following conditions or is currently experiencing any of them, please put a check next to the number and give details at the end of this section.
(ex: any problem with hearing or vision, require glasses, contacts or hearing aid)

___ 1. Asthma
___ 2. Any problem with vision or hearing – requires glasses, contacts, or hearing aid)

___ 3. Problems with teeth-use of denture or bridge
___ 4. Dizzy spells, fainting, convulsions, persistent headaches
___ 5. Motion sickness
___ 6. Frequent infection of throat, tonsils, sinuses, ear
___ 7. Chronic cough, bronchitis, bloody sputum
___ 8. Shortness of breath
___ 9. Chest pains on exertion or deep breathing
___ 10. Palpitation of the heart, irregular heartbeat, heart murmurs, or poor circulation
___ 11. Low or high blood pressure
___ 12. Frequent nausea or vomiting, food intolerances, heartburn
___ 13. Jaundice or hepatitis
___ 14. Frequent diarrhea or blood in the stools
___ 15. Frequent abdominal cramps, severe menstrual cramps
___ 16. Hernia
___ 17. Difficulty urinating, burning or pain on urination, frequency in urinating and bed-wetting
___ 18. Kidney infection or stones
___ 19. Chronic pain in neck, back, shoulders, arms, or legs
___ 20. Broken bones, joint dislocations, serious sprains, weakness of muscles
___ 21. Joint pains, swelling or stiffness without injury
___ 22. Any severe injury to head, chest, or internal organs
___ 23. Severe illness requiring hospitalization or prolonged incapacitation
___ 24. Chronic skin problems (rash, infection)
___ 25. Reaction to extremes of temperature, frostbite, impaired circulation
___ 26. Claustrophobia, agoraphobia, acrophobia (strong fear of confined places, open areas, or heights)
___ 27. Continuing use of alcohol, drugs, or medicines
___ 28. Episodes of depression, anxiety, hysteria, nervousness
___ 29. History of diabetes, thyroid trouble, bleeding problems
___ 30. Currently on any medication * If so, what? _____
___ 31. Special dietary restriction. Is the applicant a vegetarian/ macrobiotic?
AZUSA PACIFIC UNIVERSITY cannot guarantee meeting any special requirements
___ 32. Hypoglycemia
___ 33. Seen a chiropractor or participated in physical therapy
___ 34. Eating disorder (anorexia nervosa or bulimia), past or present

If you checked any of the items above, please list details below according to item number. Be specific (e.g. include dates, names of medication, history of condition, etc.) Use additional paper if necessary.
Item No._____
_____
_____
_____

If the student is receiving medication, please bring adequate amounts of the medication to the school in waterproof, unbreakable containers, along with dosage instructions.

35. Is the applicant allergic to any of the following?
Medication (e.g. penicillin, aspirin, sulfa, etc.?) _____
Foods (e.g. shellfish, etc.?) _____
Insect bites (e.g. bee stings, etc.?) _____
Other (e.g. materials, etc.?) _____

Completed by: _____ **Date:** _____