SCSU Outdoor Endeavors
Medical History & Emergency Authorization

I authorize the treatment by a qualified and licensed medical doctor in the event of a medical emergency, which in the opinion of the attending physician, may endanger my life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to contact my emergency contacts. This consent is valid while I am a participant on the Husky Adventures Trip. This consent is signed for the sole purpose of authorizing medical treatment under emergency circumstances.

_____

Participant Name Printed Age & Birthdate Date

If under 18 years of age, parent/guardian completion is required!

Emergency Contact Information & Personal Information

First Contact Person **Second Contact Person**

Name: _____ Name: _____

Relation: _____ Relation: _____

Day Phone: _____ Day Phone: _____

Evening Phone: _____ Evening Phone: _____

Physician: _____ Physician Telephone: _____

Name of Medical Insurance Carrier: _____

Policy Number & Insurance Carrier Phone Number: _____

Insurance Identification Number of Covered Person: _____
(The trips do not provide health, medical or disability insurance coverage for any participant. Each participant is encouraged to obtain his or her own medical or health insurance coverage.)

MEDICAL AND HEALTH INFORMATION *Use the reverse side if you need more space

A. Allergies (i.e. medicines, foods, bee stings)

_____NONE KNOWN (Initial)

Allergy	**Reactions**	**Medication Required**

B. Medications (i.e. over the counter & prescription)

_____NONE (Initial)

Medication	**Condition**	**Dosage (amount/frequency)**	**Side effects**

Name of Trip: Dates of Trip:

C. Physical conditions requiring special considerations, including previous and existing injuries, surgeries, or serious diseases (i.e. diabetes, heart disease, epilepsy, communicable diseases)

_____NONE (Initial)

Date Explanation Current problems

D. Any Special Dietary Needs: (food allergies, vegetarian, etc.)

NONE (Initial)

Type of food Past reactions Past/Current treatment

E. Physical impairments, limitations and other pertinent medical information:

_____NONE (Initial)

Date of Last Tetanus Shot: _____

The above information is a complete and accurate statement of the health factors that may affect my ability to participate in a SCSU Outdoor Endeavors activity. I realize failure to release information could result in serious harm to me or other participants. In the case of an emergency, I consent to allow SCSU Outdoor Endeavors to release this information to the medical personnel or medical facility involved in my treatment.

Participant Name: _____Date: _____

Signature: _____Date: _____

For participants under the age of 18, parental consent is required.

Parent Name: _____Date: _____

Parent Signature: _____Date: _____

*All medical information is CONFIDENTIAL and is not shared with anyone other than the SCSU Outdoor Endeavors staff, trip leaders and medical care providers in case of medical emergency.

Name of Trip: Dates of Trip: