

THOMPSON RIVERS UNIVERSITY



Adventure Studies Department

Medical Form

TO BE COMPLETED BY PARTICIPANT

Name: _____	Home Phone: _____
Address: _____ _____	Cell Phone: _____
	Email: _____

Health Insurance Card Number: _____	Is the Applicant covered by a public/provincial medical plan? Yes <input type="checkbox"/> No <input type="checkbox"/> By which province? _____
Birthdate (day/month/year): _____	
Height: _____	
Weight: _____	

Family Physician: _____	Does the Applicant have other private medical insurance coverage? Insurance Company: _____ Policy number: _____ Phone: _____
Phone: _____	
Fax: _____	
Address: _____ _____	

EMERGENCY CONTACTS: (Person to be notified in case of emergency)

Name: _____	Name: _____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Relationship: _____	Relationship: _____

EACH PARTICIPANT IS RESPONSIBLE FOR ANY MEDICAL EXPENSES, INCLUDING MEDICAL EVACUATION AND SHOULD BE COVERED BY THEIR OWN SICKNESS AND ACCIDENT INSURANCE.

MEDICAL HISTORY:

1. Give a brief statement of your general health:

2. Height: _____

Weight: _____

3. Do you have any present medical problems? No Yes – Describe:

4. Are you taking any medications? No Yes – Describe:

5. List Medications including name, schedule with dosage amounts (in as much detail as possible please).

Name of Medication/ What is it used for?	Schedule of Administration	Dosage Amounts

6. You must have a current tetanus immunization. No Yes – Describe:
Have you had on within last 10 years?

7. Have you had any surgeries? No Yes – Give approx. dates/details:

8. Are you allergic to any of the following?
[Please list all allergies and describe nature and severity of reaction].

a. Medications No Yes – Describe:

b. Foods No Yes – Describe:

c. insect bites No Yes – Describe:

d. other No Yes – Describe:

9. Do you carry an Epi-pen? No Yes – For which allergies?

10. Do you smoke? No Yes – Describe:
11. Have you had or do you have a substance abuse problem (alcohol, drugs, etc.)? No Yes – Give Details:
12. Do you have problems with vision or hearing? No Yes – Describe:
13. Do you have motion sickness? No Yes – Describe severity:
14. Do you have a history of high blood pressure or hypertension? No Yes – Describe:
15. Do you have heart murmurs; episodes of irregular heart beat; shortness of breath or chest pain on exertion? No Yes – Describe symptoms:
16. Do you have asthma? No Yes
- If yes, what triggers your asthma?
- Has it been stable for the past year? No Yes
- Do you take medication for your asthma? No Yes – **Please list medications used in Section #5.**
17. Have you had or do you have ulcers, heartburn, or other intestinal problems? [If so, describe diet requirement] No Yes – Describe:
18. Do you require a special diet? [If vegetarian, list what you do not eat.] No Yes – Describe:
19. Do you have any eating disorders: anorexia, bulimia? No Yes – Describe:
20. Have you had Hepatitis? No Yes – Explain:
21. Have you had Jaundice? No Yes – Explain:
22. Do you have chronic bladder infections; difficulty with urination; bedwetting or other bladder or kidney problems? No Yes – Describe:
23. Do you have seizures? List medications and dosages in #5. No Yes – Describe severity and frequency:
24. Do you suffer from sever headaches, dizziness or fainting? No Yes – Identify and describe:
25. Have you ever had a brain injury requiring treatment? **Includes concussions.** No Yes – Give date and severity:
26. Do you have claustrophobia, agoraphobia, acrophobia? [strong fear of confined places, open areas, heights] No Yes – Describe:

27. Do you have problems with your neck, back, arms, ankles or knees that limit your activities? No Yes – Describe:
28. Do you have bleeding problems? No Yes – Describe:
29. Do you have diabetes, hypoglycaemia, thyroid trouble or other endocrine problems? No Yes – Describe:
30. Do you have chronic skin problems (rashes, sun sensitivity, etc.)? List medications required for treatment in #5. No Yes – Describe:
31. Have you had frostbite or a reaction to cold temperatures? No Yes – Explain and describe severity:
32. Have you suffered from muscle cramps, heat exhaustion or had other reactions to warm temperatures? No Yes – Explain:
33. Does your health prevent you from participating in any physical activities? No Yes – Explain:
34. Do you have any communicable diseases? No Yes – Please indicate the nature of the disease:
35. Have you ever seen a psychiatrist, psychologist or psychotherapist?
If “Yes”:

Are you currently under treatment? No Yes

Have you been under treatment within last two years? No Yes

Reasons for treatment:

- Family Issues
- Relationship Issues
- Depression/Mood Disorder
- Eating Disorder
- Substance Abuse
- Attempted Suicide
- Attention Deficit Disorder
- Psychiatric Hospitalization
- Other [describe]

Name of therapist so we may contact:

Name: _____

Phone: _____

Please provide written permission to your therapist so that we may contact him/her.

Have you done so? No Yes

36. Do you snore or breathe noisily during sleep? No Yes – Describe:
37. Do you have any trouble communicating in English? No Yes – Describe:
38. For females: Are you pregnant? No Yes – Due date:
39. For females: Do you have premenstrual or menstrual problems? No Yes – Describe:
40. Do you have a learning disability? List medications required for treatment in #5. No Yes – Please describe:
41. What is your swimming ability? (It is strongly recommended that ALL participants be able to swim at least 100m) Non-swimmer
 Can swim at least 100m
 Strong swimmer
 Hold current lifesaving certificate
42. Please describe in detail what you do routinely to maintain an active lifestyle (mention activities and frequency) Describe:
43. If you are over 30 years of age and any of the following conditions apply to you, we STRONGLY SUGGEST that you discuss with your physician the advisability of taking a stress electrocardiogram. Please check the following if applicable:
- High blood pressure
 - Long-term sedentary lifestyle
 - Diabetes
 - Smoke one or more pack of cigarettes daily
 - Overweight or obesity
 - A family history of heart disease
 - Previous cardiovascular disease

Consent is hereby given for the applicant to attend a TRU course and permission is given for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary. I understand that the program involves physically and mentally strenuous activity in a remote wilderness area for removed from the facilities of civilization.

The information provided above is a complete and accurate statement of the physical and psychological factors which may affect my participation in TRU. I realize that failure to disclose such information could result in serious harm to myself and fellow participants and agree to indemnify and hold TRU harmless if all relevant information is not disclosed.

Applicant's Name (please print)

Date

Applicant's Signature