



HEALTH HISTORY FORM

(Please print and complete all sections.)

Part B

FIRST NAME _____ LAST NAME _____

HEIGHT: _____ inches WEIGHT: _____ pounds (these are important to help us place you in the correct trip)

DATE OF LAST MEDICAL EXAM: _____

REQUIRED IMMUNIZATION:

Immunization	Required Interval	Last Immunization Date	Exemption
Tetanus	Within 10 years of September 1, 2013. Recommended within 5 years.	_____	<input type="checkbox"/> Religious

CURRENT HEALTH STATUS: Please indicate if you have any medical conditions or physical disabilities that could interfere with or limit your participation in the trip. If you are unsure, explain the trip to your physician and ask for his/her advice. *(This will not necessarily prohibit your participation, but for your own safety, we must be aware of such conditions.)* If you answer yes to any of the questions below, please specify in detail section below, indicating the item number. All information is kept strictly confidential. Attach additional sheets if necessary.

1. Hearing or Vision Problems (do <u>not</u> include wearing glasses or contacts)	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Frequent Muscle Cramps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Respiratory Problems (do <u>not</u> include minor ones)	<input type="checkbox"/> Yes <input type="checkbox"/> No	10. High or Low Blood Sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Seizure Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Joint Problems (e.g. knees, ankles, hips, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Anemia, Bleeding tendencies or Traits	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Serious Illness or Hospitalizations in last year.	<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Psychological or Emotional Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Surgeries in last 6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	14. Smoker	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Heart Problems or High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Other Medical Conditions	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Serious Reaction to High or Low Temperatures	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Item #	Detailed description (include restrictions, if any). Add a separate sheet if necessary.

ALLERGIES: Please indicate any allergies you have (medications, foods, etc.), your allergic reactions, and any medication required.

Allergies Reactions (check if applicable, write in others)	Check Yes/No	Reaction (if any)	Medication Required (if any)
Reaction to Insect stings (bees, wasps, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Reaction to Iodine or Shellfish?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Reaction to Peanuts (legumes)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Reaction to Nuts?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Reaction to Latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No		



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MEDICATIONS: Please indicate any medications you are currently taking (other than allergy medications), for what condition, and whether you will need to take it during the trip. If you need to take medication during the trip, be sure you have an ample supply.

Medication	Condition	Do you need this during the trip?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

DIETARY RESTRICTIONS OR FOOD ALLERGIES: (Please indicate specific dietary restrictions: Vegetarian, Vegan, Kosher, Halaal, lactose intolerant, etc.)

<input type="checkbox"/> No Special Menu <input type="checkbox"/> Vegetarian <input type="checkbox"/> Vegan <input type="checkbox"/> Kosher <input type="checkbox"/> Halaal
Other Dietary Needs/Food Allergies: Enter information below or send us additional information by letter (Lactose intolerant, gluten allergy, Crohn's Disease, etc. please indicate any more specific dietary restrictions.) We will do our very best to meet your dietary requirements. However, we do have limitations in terms of the types of food that we can bring on an outdoor trip so if you have certain special needs, you might be required to bring some of your own food. Contact the OA Office if you have questions.
Special Dietary Needs:

SWIMMING ABILITY:
 Cannot Swim
 Poor Swimmer
 Fair Swimmer
 Good Swimmer
 Very Good Swimmer

What level of trip would you be most comfortable with? (select one)

<input type="checkbox"/> 1 – Easy	<input type="checkbox"/> 2 – Moderate	<input type="checkbox"/> 3 – Strenuous	<input type="checkbox"/> 4 – Very Strenuous
Base Camp trip. Most activities are in camp. Some light hiking, 4–6 miles on flat terrain	4–7 miles of hiking/day on relatively flat terrain or shorter mileage on moderately hilly terrain	6–10 miles of hiking/day on moderately hilly terrain or shorter mileage on moderately hilly terrain	8–10 miles of hiking/day possibly on steep terrain

CURRENT PHYSICAL CONDITION: Please *check only one box* to rate your current physical fitness level.

I. I don't participate regularly in programmed recreation sport or physical activity:	
<input type="checkbox"/>	Avoid walking or exertion (e.g. always use elevator, drive whenever possible instead of walking)
<input type="checkbox"/>	Walk for pleasure, routinely use stairs, occasionally exercise sufficiently to cause heavy breathing or perspiration.
II. I participate regularly in recreation or work requiring modest physical activity, such as golf, horseback riding, calisthenics, gymnastics, table tennis, bowling, weight lifting, or yard work:	
<input type="checkbox"/>	10 to 60 minutes per week
<input type="checkbox"/>	Over one hour per week
III. I Participate regularly in heavy physical exercise (such as running or jogging, swimming, cycling, rowing, skipping rope, running in place) or engage in vigorous aerobic type activities (such as tennis, basketball, or handball).	
<input type="checkbox"/>	Run less than one mile per week or spend less than 30 min per week in comparable physical activity.
<input type="checkbox"/>	Run 1 to 5 miles per week or spend 30 to 60 min per week in comparable physical activity.
<input type="checkbox"/>	Run 5 to 10 miles per week or spend 1 to 3 hours per week in comparable physical activity.
<input type="checkbox"/>	Run over 10 miles per week or spend over 3 hours per week in comparable physical activity.

CURRENT EXERCISE ACTIVITY:

Do you exercise regularly? No Yes

If yes, list any physical activities or sports you engage in, times per week, duration, and level of intensity.

Activity	Times/Week	Approximate Time/Distance	Level of Intensity
			<input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely
			<input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely
			<input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely

OTHER INFORMATION: Attach additional sheets for other pertinent medical or health history information or physical condition