(Please complete all sections and please print.) Rev. 3/9/98

FIRST NAME_____ **LAST NAME** _____ **CLASS**_____

HEIGHT(in inches): _____ **inches** **WEIGHT:**_____ **pounds** **AVERAGE RESTING PULSE RATE:**_____

CURRENT PHYSICAL CONDITION: Please check the highest activity level in each category that you feel you can comfortably attain.

Walking (average 3 mph)	❑ 2 miles in 40 minutes	❑ 4 miles in 80 minutes	❑ 6 miles in 120 minutes	❑ Unsure
Jogging (average 5 mph)	❑ 1 mile in 12 minutes	❑ 3 miles in 36 minutes	❑ 5 miles in 60 minutes	❑ Unsure
Cycling (average 10 mph)	❑ 5 miles in 30 minutes	❑10 miles in 60 minutes	❑ 20 miles in 120 minutes	❑ Unsure

CURRENT EXERCISE ACTIVITY: List any physical activities you engage in, their frequency, duration and level of intensity.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

SWIMMING ABILITY: ❑ **Nonswimmer** ❑ **Poor** ❑ **Fair** ❑ **Good** ❑ **Very Good**

REQUIRED IMMUNIZATION: **If your Tetanus has expired, contact McCosh Health Center at 8-6229.**

Immunization	Required Interval	Last Immunization Date	Exemption
Tetanus	Within 10 years of September 1, 1998. Recommended within 5 years.		❑ Religious

CURRENT HEALTH STATUS: Please indicate if you have any medical conditions or physical disabilities that would 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. *(None of these will 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 below, indicating the item number.

1. Hearing or Vision Problems (do not include wearing glasses or contacts)	❑ Yes ❑ No	6. Serious Reaction to High or Low Temperatures	❑ Yes ❑ No
2. Respiratory Problems (do not include minor ones)	❑ Yes ❑ No	7. Frequent Muscle Cramps?	❑ Yes ❑ No
3. Back Problems	❑ Yes ❑ No	8. High or Low Blood Sugar	❑ Yes ❑ No
4. Joint Problems (e.g. knees, ankles, hips, etc.)	❑ Yes ❑ No	9. Seizure Disorders	❑ Yes ❑ No
5. Any Recent Serious Illness	❑ Yes ❑ No	10. Other	❑ Yes ❑ No

Item #	Detailed description (include restrictions, if any)

ALLERGIES: Please indicate any allergies you have, your allergic reactions, and any medication required.

Allergy (check if applicable, write in others)	Reaction	Medication Required (if any)
Insect stings (bees, wasps, etc.) ❑ Yes		
Iodine or Shellfish Allergy ❑ Yes		

DIETARY RESTRICTIONS OR FOOD ALLERGIES: (If vegetarian or Kosher, please indicate specific dietary restrictions.)

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?
		❑ Yes ❑ No
		❑ Yes ❑ No