Appalachian Mountain Club – A Mountain Classroom
Confidential Health Questionnaire (two-page form)

Participant Name: _____ Course Start Date: _____

School/Organization Name: _____

Age at Course Start: _____ Height: _____ Weight: _____ DOB_____

Home Address: _____

Emergency Contact: _____Relationship: _____

Phone Number: (day)_____ (eve):_____ (cell):_____

2nd Emergency Contact: _____Relationship: _____

Phone Number: (day)_____ (eve):_____ (cell):_____

Medical Insurance # _____ Policy # _____ Carrier's Name _____

SEVEN-QUESTION HEALTH QUESTIONNAIRE

Parent or legal guardian should complete this form for their minor child participating in an AMC activity.

	Yes	No
1. **Have you/Has your child experienced an asthma attack at any time in your/their life?** (Asthma can potentially be affected by exercising at altitude, in dry air, extreme cold, etc.)		
2. **Have you/Has your child ever been diagnosed with type I or type II diabetes?** (A diabetic can easily become dehydrated in backcountry environments. Further, long, arduous days/hikes can lead to hypoglycemia, etc.)		
3. **Have you/Has your child ever visited a medical professional for a serious allergic reaction, or have you/has your child ever been given a shot of epinephrine for an allergy or anaphylaxis?** (Some people are allergic to stinging insects; nut products or other food products, which a co-participant might be carrying or may be included in a meal prepared by AMC staff; iodine, which might be used to treat drinking water and/or clean wounds, etc.)		
4. **Have you/Has your child ever received medical treatment for angina, a heart attack, or any type of heart disorder/disease?**		
5. **Have you/Has your child ever been diagnosed with or are you/is your child currently being treated for high blood pressure?** (The environment and workload associated with AMC courses can sometimes affect BP and/or the efficiency of some BP medications.)		
6. **Have you/Has your child ever seen a medical professional following a seizure, or are you/your child currently being treated for any type of seizure disorder?** (Some seizures are triggered by fatigue and dehydration [which can occur following a long hike], significant change in diet, stress, etc.)		
7. **Is there anything else you think we should know about your/your child's medical background?** (i.e., anything that could affect your safety or ability to participate fully?)		

DIETARY RESTRICTIONS: **Please be specific** (vegetarian, no red meat, vegan, lactose intolerant, food allergies, etc.) _____

If you answered **YES** to **ANY** of the previous questions please answer the following as well:

- I/my child was diagnosed with _____in the last year.
- I have/my child has visited the emergency room in the last year due to _____.
- I have/my child has had to use epinephrine following an asthma attack/allergies or anaphylaxis in the last year. _____
  - Will you/your child be bringing/carrying epinephrine on the outing? _____
  - What are you/your child allergic to? _____
- How often do you/your child use an inhaler to treat your/their asthma or wheezing? _____
- Do you/Does your child have poor circulation due to diabetes? _____
- Will you/your child be carrying insulin or wearing an insulin pump during this outing? _____
- Are you/your child able to exert yourself/themselves for more than 30 minutes without experiencing angina (chest) pain? _____
- Are you/your child currently taking medication for your/their seizures? _____
- Have you/Has your child experienced a seizure within the past year? _____
- Is your/your child's blood pressure currently under control (i.e., systolic under 140 and diastolic between 60 and 100)? _____

If there is anything else you think we should know about your/your child's medical background, please explain here. Attach a separate sheet if necessary.

_____

_____

PLEASE READ CAREFULLY! Participants (and parents/guardians, if appropriate) must read and sign below.

Participant acknowledgement of accuracy and understanding. By signing this form, I am declaring that, to the best of my knowledge, I have completed the questionnaire accurately. I also understand that by knowingly filling out the form inaccurately, or by withholding pertinent information about my health, I could potentially be increasing the risk to myself or others.

Consent to accept aid. By signing this form, I am giving consent and permission for AMC staff, volunteers, representatives, or contractors to provide medical care to me or to my child, to transport me or my child to a medical facility, or to seek the aid of emergency medical services as deemed appropriate. I further authorize AMC staff, volunteers, representatives, or contractors to render whatever treatment they consider necessary for my or my child's health, and I agree to pay all costs associated with that care and transportation.

_____ _____

Participant's name (printed) Participant's signature

_____ _____

Signature of parent/guardian (if applicant is under 18) Date