Health Form

This health form provides information helpful for event management, meeting individual needs effectively within recreation-based programs, and in responding to emergency situations. By requesting this information, we do not imply that we have the expertise to assess your physical condition, or ability to participate safely in this program.

If you have any doubts about your ability to participate in this program, please consult with your physician. The information you provide is confidential, and will be shared only as needed with program staff, volunteers, and medical care providers.

Participant Information		
First Name	**Last Name:**	**Preferred Pronouns:**
Address:	**City:**	
Email Address:	**State:**	**Zip Code:**
Cell Phone:	**Home Phone:**	
[__] I am a minor or have a legal guardian	**Date of Birth:**	
Emergency Contact		
Name/Relationship:	**Emergency Contact Phone:**	
Primary Physician Name & Phone:	**Legal Guardian Name & Phone** (if applicable)	
Medical Insurance Provider:	**Insurance Policy #**	

Military Service: [_] I have served		**[_] My family member has served**
Branch of Service:		**Relationship:**
Rank:		**[_] I am a caregiver for a service Member or Veteran with a disability.**
Era of Service: Post 9/11 Gulf War Vietnam Korean War WWII		

Health Information		
Height:	**Weight:**	**General Physical Condition:** **Poor Fair Good Excellent**
Disability/Diagnosis: **Date of injury/onset:**		
Allergies (i.e. bees, plants, drugs, food). Please describe the nature and severity of reaction. **Do you carry an EpiPen?**		
Are you currently receiving treatment by a physician for any illness or injury? If yes, please explain.		

First Name		Last Name:	
	Yes	**No**	
Do you utilize assistive devices?			**List Assistive Devices:**
Are you independent with mobility?			
If you use a wheelchair, are you independent with your transfers?			

	Yes	**No**	**Medication, Treatment, Explanation**
Diabetic?			
Traumatic Brain Injury?			
History of seizures or seizure disorder?			
Blind or visually impaired?			
Deaf or hard of hearing?			
Limited range of motion in any limbs?			
Difficulty with balance?			
Wear any sort of spinal stabilization?			
Any type of paralysis?			
Sensitivity to hot or cold?			
Difficulty speaking or communicating?			
Difficulty remembering or following directions?			
Emotional and/or behavioral concerns we should know about?			
Personal care or independence concerns?			
Intellectual or developmental delay?			
Heart/Cardiac condition?			
Respiratory condition?			

Do you experience any non-visible disabilities (ie PTS, ADHD, Anxiety, Dementia, etc.) that could be better supported through changes or adaptations to our instructional style?
Please list any other medical conditions or considerations not mentioned above (i.e. medication side effects, bone disease, easily fatigued, weakened immune system, pregnancy, infectious disease, etc):

I certify the information provided in this form is true and correct. To the best of my knowledge, I am able to participate safely in this program. I hereby consent for myself, or the participant referenced of whom I am guardian, to receive medical treatment if an illness/injury is incurred during the program.

Form Completed By Name:	
Signature	Date

Return this form to **Northeast Passage** • 121 Technology Drive, Suite 161, Durham, NH 03824 • northeast.passage@unh.edu • Fax: (603) 862-0249 •Phone:(603) 862-0070