Appalachian Mountain Club
August Camp Confidential Health Questionnaire

Participant Name: _____ Which weeks are you attending? (Circle)
1 2 3 4

Age at Camp Attendance: _____ Height: _____ Weight: _____

Home Address: _____
City *State* *Zip*

Emergency Contact(s): _____ Primary Emergency Phone Number: (day)_____

(eve):_____

Emergency Cell Phone/Page:_____

Relationship of Emergency Contact(s): _____

Address: _____ _____
Street *City* *State* *Zip*

SEVEN-QUESTION HEALTH QUESTIONNAIRE

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

	Yes	No
1. Have you experienced an asthma attack at any time in your life? (Asthma can potentially be affected by exercising at altitude, in dry air, extreme cold, etc.)		
2. Have you 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 ever visited a medical professional for a serious allergic reaction, or have you 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 ever received medical treatment for angina, a heart attack, or any type of heart disorder/disease?		
5. Have you ever been diagnosed with or are you currently being treated for high blood pressure? (The environment and workload associated with August Camp can potentially affect BP and/or the efficiency of some BP medications.)		
6. Have you ever seen a medical professional following a seizure, or are you 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 medical Background? (i.e., anything that could affect your safety or ability to participate fully?)		

Food allergies (Please indicate the type and severity of reaction):

_____

_____

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

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

If there is anything else you think we should know about your 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