Appalachian Mountain Club
August Camp Confidential Health Questionnaire

Participant Name: ______________________________ Which weeks are you attending?
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):

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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.

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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