State University of New York College at Cortland
Adirondack Trail Blazers

Medical Information Form

Directions: Please complete the following information to assist course planning and emergency medical services for the Adirondack Trail Blazers at the SUNY Cortland Outdoor Education Center and in the Adirondack Park. This information is confidential and will only be shared with course faculty and staff as well as health care personnel in order to ensure a safe and enjoyable participation for you and others.

Personal Information

Name: _____ Sex: ☐ F ☐ M DOB: _____

Permanent Home Address: _____

Cell Phone: _____ Home Phone _____

T-shirt size: S ☐ M ☐ L ☐ XL ☐ XXL ☐

Emergency Contact:
Name: _____ Relationship: _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____

Physician, clinic, health care provider: _____

Health Insurance Policy #, Company, Group #: _____

CONFIDENTIAL PERSONAL HISTORY - to be viewed by course instructors ONLY

1. Please describe your level of physical activity and health.

2. Does your health prevent or restrict you from participating in any physical activities? YES ☐ NO ☐
   If YES, please describe.

3. Are you currently undergoing treatment by a physician for any medical/mental health condition?
   YES ☐ NO ☐ If YES, describe the condition and treatment below:

4. Please identify any medical conditions or diseases which you have experienced or presently experience (check **all** that apply):

☐ heart disease	☐ seizure disorder	☐ heart issues	☐ traumatic brain injury
☐ recent surgery	☐ migraine headaches	☐ asthma	☐ lung disease
☐ diabetes	☐ dizziness	☐ abdominal pain	☐ kidney stones
☐ Lyme disease	☐ fainting	☐ stroke	☐ vision problems
☐ pregnancy	☐ mental health issues	☐ arthritis	☐ sleepwalking
☐ hypoglycemia	☐ high blood pressure	☐ chronic ear problems/hearing loss	
☐ chronic stomach/intestinal problems		☐ orthopedic/ joint problems (neck, back)	
☐ only one of a paired organ (kidney, testicle, eye, lung, etc…)			
☐ other (please specify): _____			

If you checked any of the above please explain/describe below:

5. Please identify previous, current or anticipated **allergic reactions** to any of the following:

☐ hay fever	☐ molds	☐ bees/wasps/insects
☐ trees	☐ wool	☐ medications (e.g., penicillin)
☐ down/feathers	☐ iodine/shellfish	☐ specific foods (e.g., nuts)
☐ animals	☐ other (please specify):	

For each item checked, describe your allergic reaction(s) including treatment below:

6. Are you taking any **over the counter or prescription medications**? YES ☐ NO ☐
If yes, please list all medication(s) you are taking, the **dosage, frequency of use,** and **reason for use**.

Do you have any dietary restrictions (vegetarian, vegan, lactose intolerant, etc.) YES ☐ NO ☐
If yes, please indicate.

7. Do you use tobacco? YES ☐ NO ☐ If YES, how frequently? _____
PLEASE NOTE: SUNY Cortland is a tobacco free campus and the use of tobacco is prohibited on all school grounds. Please plan accordingly.

8. Date of last Tetanus Booster: _____ **PLEASE NOTE:** Because of our remote location at camp and on a canoe trip in wilderness areas of the Adirondack Park, it is **required** that you have a current Tetanus Booster within the past 10 years as of the date of your program.

9. Blood type (if known): _____

10. If you have any phobias (an exaggerated usually inexplicable and illogical fear), please check those that apply to you.
☐ Altophobia (heights) ☐ Claustrophobia (confined spaces) ☐ Nyctophobia (dark)
☐ Other (please explain): _____

11. Swimming ability: ☐ Weak ☐ Moderate ☐ Strong

12. Is there additional information pertinent to your participation in this course that the staff should know to help keep you safe and healthy?

Due to the rugged and remote setting of the course, access to a hospital and/or medical facilities is limited. By signing my initials below, I am giving consent for medical treatment to the instructor and medical personnel in an emergency situation when I am incapable of making the decision myself.

Initials: _____

Please discuss any conditions, treatments, and concerns with your instructor/leader prior to your trip (and during if conditions warrant it).

By signing this document I indicate that I have provided accurate information to help make the Adirondack Trail Blazer experience safe and enjoyable for myself and others. I have read all of the information provided to me and understand my responsibilities to be prepared. I realize that participation in the course will be a challenging learning experience and that I may be exposed to potential health risks. I willfully choose to participate in this program and assume the risk involved.

Signed:_____ Date:_____

Witness: _____ Date:_____
Your responses to this questionnaire will be held in confidence by the instructors. The information will only be used for risk management during your participation in Adirondack Trail Blazers course/events.

Reviewed by:
Instructor_____ Date_____ Instructor_____ Date_____ Instructor_____ Date_____