appalachian expeditions

rooted in adventure | rooted in appalachia

To be completed by participant of parent/s (if participant is under 18)

Appalachian Expeditions ("APEX") collects medical information to endeavor to provide more successful experiences and to assist in managing risks faced by our participants. APEX's programs vary greatly in environmental conditions, physical difficulty, and access to professional medical care. Please contact us if you have any questions about these issues or the activities and risks associated with your specific program as you complete this form. APEX treats all medical information with some degree of confidentiality. Enrolled participant medical information is shared with our staff, who oversee the participants during the program.

Today's Date: _____

Participant Name:_____

APEX Program: _____

Participant DOB:_____, Age: _____, Gender: _____

Parent/Guardian Info OR Emergency Contact Info (if over 18):

Full Name: _____
Relationship to Participant: _____
Cell Phone: _____
Daytime Phone: _____
Evening Phone: _____
Email:_____

2nd Parent/Guardian Info OR Emergency Contact Info (if over 18):

Full Name: _____
Relationship to Participant: _____
Cell Phone: _____
Daytime Phone: _____
Evening Phone: _____
Email:_____

Family Physician Name:_____
Phone:_____
Address:_____

Medical Insurance Information:
Medical Insurance Carrier:_____
Policy/Group Number:_____
Prescription Plan Number:_____
Phone Number:_____
Please include a copy of insurance card*

Participant Health Information

Participant Height:_____ Participant Weight:_____
Date of last tetanus immunization: _____

Past and Present Medical Health Issues: Does participant currently have, or have a history of treatment, for any of the following conditions? If yes, please explain. If you indicate below that the participant has any **Allergies, Dietary/Needs Restrictions, Medications, Mental Health Issues/Illnesses, or Orthopedic Injuries/Issues**, please complete the forms on the following pages.

- ❑ **Allergy** (bee/insect stings, shellfish, iodine, nuts, dairy, other foods, pollen, medications, and any other known allergies)
- ❑ Anemia/Sickle Cell Trait
- ❑ Asperger's, Autism or NLD OR PDD
- ❑ **ADD/ADHD or other Learning Disorders**
- ❑ Bleeding/Blood Disorder
- ❑ Cancer
- ❑ Cardiovascular (heart and vessels) Abnormalities or Problems, including high blood pressure
- ❑ Chronic or Episodic Illness/Condition
- ❑ Circulatory Problems
- ❑ Dental Problems/Issues
- ❑ Diabetes *CALL
- ❑ **Dietary Needs/Restrictions** (including medical, religious, ethical, or other)
- ❑ Ear, Eyes, Nose & Throat Infections/Issues/Problems
- ❑ Eating Disorder (anorexia, bulimia, etc.)
- ❑ Epilepsy or Other Seizure Disorder *CALL
- ❑ Fainting or Dizziness, chronic
- ❑ Gastrointestinal Problems, Ulcers
- ❑ Head Injury, Concussion or Severe Headaches
- ❑ Heat Injury/Illness
- ❑ Hepatitis
- ❑ Hormonal/Thyroid
- ❑ Hypertension
- ❑ Kidney or Liver Disease or Issues
- ❑ Skin/Acne Issues
- ❑ Menstrual Cramps/Problems
- ❑ **Medications** (prescription, over-the-counter, dietary supplements, herbal remedies,and any other medications).
- ❑ **Mental Health Issues/Illnesses** (anxiety disorders, depression, history of suicide attempt or ideation, addiction, self-abuse, or any other mental health issues).
- ❑ Neurological Disorders
- ❑ **Orthopedic Injuries/Issues** (Recurrent Strains or Sprains, Musculoskeletal, and other Athletic Injuries: shoulder, arm, elbow, hand, neck, back, hips, leg, knee, ankle, foot)
- ❑ Pregnancy, current *CALL
- ❑ Reproductive Tract
- ❑ Respiratory Tract, Including Asthma
- ❑ Skin Problems/Issues
- ❑ Sleepwalking
- ❑ Sudden death under age 50 of family member *CALL
- ❑ Syncope with exertion (fainting during exercise) *CALL
- ❑ Tobacco, regular use and/or addiction *CALL
- ❑ Urinary Tract
- ❑ Vision or Hearing Issues or Impairment
- ❑ Other, including hospitalization in last 5 years (explain)

Has participant been under the care of a physician in the last 12 months? If "Yes,"please explain why:

Considering the information you have provided above or otherwise, does the participant have any condiiton/s (e.g. mental, physical, emotional) which might affect or limit their well-being, the well-being of others, or the participants ability to engage in APEX activities? Please include any adaptations or modifications appropriate or necessary.

For each item checked on previous page, especially those in bold, please fully explain the history, current status, and note the treating physician's name and phone number below or on additional pages.

Swimming Ability
Participant's ability to swim in deep water (over 5 feet); consider participant's comfort level and physical condition. **Circle: Strong, Competent, Poor, Non-swimmer**

*Note: Please let us know if you have any specific concerns about participant's participation in swimming or water based activities, and/or if participant has a fear of the water. Some APEX programs require a higher competency level than others. For poor or non-swimmers, please contact us to discuss appropriate program placement for your child.

SIGNATURE REQUIRED FOR ACKNOWLEDGEMENT/AGREEMENT AND MEDICATION AUTHORIZATION

If the participant is a minor (under 18 years of age), parents/guardians must sign below. If the participant is an adult (18 years of age or older), the participant must sign below.

ACKNOWLEDGEMENT/AGREEMENT: To the best of my knowledge, this medical form and any supplemental medical information I submit (any supplemental information incorporated by this reference) contains accurate information. I understand the nature of APEX activities, and acknowledge that I can contact APEX should I have any questions about these activities or the associated physical, mental, or emotional demands or other concerns. Other than any limitations described in this form (or in information submitted by the participant's health care provider/s), the participant agrees, and has permission from his or her parent/s if he or she is a minor, to participate in all APEX activities. I agree to contact APEX if any medical or health condition changes before the start of the APEX program. I understand that providing inaccurate medical or health information or falsifying medical or health information can create serious risks to the participant or others, and/or can result in the participant's dismissal from the program. I understand the participant's final acceptance and participation in the program is contingent upon APEX representatives' review of all forms, including this one. I understand that although APEX will review this information and may allow participation, APEX cannot anticipate or eliminate risks or complications posed by a participant's mental, physical, or emotional condition. I understand that emergency, medical, drug and/or health issues, response, assessment or treatment are included within the scope of – and expressly subject to the terms of – the APEX Acknowledgment and Assumption of Risks & Release and Indemnity Agreement. Please review that Document carefully in regard to the activities, risks and your responsibilities.

Note: I consent here to allow APEX staff or its consulting health care providers to contact and communicate with the participant's health care provider/s listed in these forms about the participant's health and medical condition or care. APEX keep sand provides regular over-the-counter medications for minor illnesses (headaches, cramps, cold & flu, sore throat, etc.) and asks that participants do not bring them. Signing this Acknowledgement/Agreement gives APEX permission to administer over- the-counter medications.

MEDICAL AUTHORIZATION

I authorize APEX staff, representatives and/or other medical personnel to obtain or provide medical care for the participant, to transport the participant to a medical facility, and/or to provide treatment (including, but not limited to hospitalization, medications, injections, anesthesia, or surgery) they consider necessary for the participant's health. I agree to the release (to or by APEX) of any records necessary for treatment, referral, billing, or insurance purposes. I agree that APEX has no responsibility for medical care provided to the participant, and agree to pay all costs associated with this care, including but not limited to medical evacuation, travel, compensation and expenses for staff accompanying the participant, medicine and treatment. This form may be photocopied for use in the field.

Participant Name (Printed)	Participant Signature	Date
1st Parent Name (Printed)	1st Parent Signature	Date
2nd Parent Name (Printed)	2nd Parent Signature	Date