Department of Recreational Sports Loyola University Maryland

HEALTH AND MEDICAL RECORD

To assist you in assessing your ability to succeed safely in our programs, and to enable us to assist you in case of an emergency, please complete this Health and Medical Record. Please note that the Department of Rec. Sports does not administer medications (unless to children), except in emergencies, and we accept no responsibility for determining an individual's fitness to participate in Outdoor Adventure Experience Programs. **Any questions you may have about your ability to participate should be directed to your physician.** The information you are providing in this Health and Medical Record will be treated confidentially. It will not be released to anyone without your permission, except in an emergency situation where you are unable to otherwise communicate your wishes.

GENERAL

Name_____ Student ID #_____
Last First MI

Address _____ Cell# (_____)_____

_____ D.O.B._____/_____/_____

_____ Height_____ Weight_____

M_____ F_____

Class Year_____

EMERGENCY

In case of emergency notify_____ Relation_____

Phone# (Day) (_____)_____ (Evening) (_____)_____

Health Insurance Company _____ Policy #_____

Policy Holder's Name _____ Group #_____

MEDICAL HISTORY

1. Please rate your current level of physical activity

Activity	Times Per Week	Times Per Week	Times Per Week	
Walking	1-2	3-5	5+	N/A
Jogging	1-2	3-5	5+	N/A
Cycling	1-2	3-5	5+	N/A
Aerobics	1-2	3-5	5+	N/A
General Sports	1-2	3-5	5+	N/A
Swimming Ability	Beginner	Intermediate	Advanced	None

Are you Currently Pregnant? No Yes

Are you a Smoker? No Yes

Have you ever experienced an **Anaphylaxis Reaction?** No Yes

Do you have any **Allergies?** No Yes* Do you carry personal **medications?** No Yes

*Allergy	Reaction	Treatment

Do you have **Diabetes?** No **Yes*** Do you carry personal **medications?** No Yes

*Type of Diabetes	Reaction	Treatment

Do you have **Asthma?** No **Yes*** Do you carry personal **medications?** No Yes

*Type of Asthma	Reaction	Treatment

Have you ever experienced **Seizures?** No **Yes*** Do you carry personal **medications?** No Yes

*Type of Seizures	Reaction	Treatment

Have you ever had **Cardiac Symptoms?** No **Yes*** Do you carry personal **medication?** No Yes

* Cardiac Symptoms	Reaction	Treatment

Pre-existing condition information **C = Current (within last 12 months)** **P = Past** **N= N/A**

Complete/partial hearing loss				History of heart disease (in family)			
Head injury				Palpitations (heart)			
H eat related illness				Heart murmur			
Orthopedic injury				Chest pains with or w/o exercise			
Ever dizzy or faint during exercise?				Bleeding disorder			
Shortness of breath with or w/o exercise				Stroke			
Ever told not to participate in sports?				High Blood Pressure			

Additional comments or information (if checked a current or past condition).

_____

_____

_____

2. Please list any additional illnesses or medical conditions for which you are currently being treated.

Condition	Year Diagnosed	Treatment
Condition	Year Diagnosed	Treatment

3. Please list any operations or hospitalizations you have had in the past year.

Reason	Hospital	Doctor	Date
Reason	Hospital	Doctor	Date

4. Please list additional medications you are now taking.

Name of Medication	Dose	How Often
Name of Medication	Dose	How Often
Name of Medication	Dose	How Often
Name of Medication	Dose	How Often

5. Physician Consultation

***If you responded affirmatively to any of our requests for medical information, we urge you to contact your physician to discuss your ability to participate in Outdoor Adventure Experience programs.** If you or your physician requires additional information regarding these activities, please contact us.

I have consulted with my physician about my participation in the Experiential Education program?
No Yes

If you answered yes to the previous question, please provide the physician's recommendation:

Advised to participate
Advised not to participate
Advised to use caution while participating in certain activities

6. Any Additional Comments

_____

_____

_____

_____

The foregoing information is true and correct to the best of my knowledge.

Date: _____ **Signature** _____

PARENTAL CONSENT (To be completed by parents or guardians of students under the age of 18)
The laws of Maryland require that surgical and medical treatment of minors and release of medical information to hospitals, other physicians, and insurance companies about conditions treated by us be at the request of and with the approval of their parents. This right to request and approval may be delegated to College officials. Although it is our policy to notify the parents as soon as possible in the event of major illness or injury, it is impractical to notify for every minor illness or injury requiring treatment. It will help us protect the health of your child if you will delegate to us discretion in these matters.

I give my permission for such diagnostic and therapeutic procedures as may be deemed necessary for my child and agree to present information concerning their medical condition to other responsible authorities when deemed desirable. No major operations will be preformed, except in extreme emergency, without parents being fully informed.

Signature of Parent or Legal Guardian_____

Signature of Student_____ Date_____

Please return this form as soon as possible to allow time for review. It is possible that further medical evaluation is needed to approve your participation in some OAE activities.

Loyola University Maryland
Department Recreational Sports/Outdoor Adventures
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