

Personal Health Inventory

Outdoor Program Center
Bemidji State University



The OPC is glad to have as many people as possible participate in our programs. Please be aware that many of our trips operate in areas far from hospitals and advanced medical support. It is important that you realize that in activities conducted in the wilderness help may be days away. Rescue may be difficult and very expensive. What may be a minor injury in town could result in death in the wilderness. By obtaining the most detailed and correct medical information possible from the trip participants and through rigorous pre-trip planning we can avoid serious medical events.

Please print everything clearly. All information will remain confidential.

Trip Name _____

Dates _____

Name _____
(Last) (First) (MI)

Address _____
(Street) (City) (State) (Zip)

Home Phone _____ Social Security number _____
(Area code)

Sex _____ Height _____ Weight _____ Birthdate _____
(Month/Date/Year)

Emergency Contact:

Name _____ Relationship _____

Address _____
(Street) (City) (State) (Zip)

Home Phone _____

Work Phone _____

Do you have health insurance? Yes _____ No _____

Name of health insurance company _____

Policy number _____

NOTE: BSU does not provide health/medical insurance for course participants, you are responsible for health care costs incurred during the course of the trip.

Continued on back.

Please list specific items after each question.

Please list all allergies (drugs, insects, food) _____

Are you currently taking any medications? Please list _____

Do you have any dietary concerns (vegetarian, lactose intolerance, food allergies)?

Explain _____

For your safety and the safety of other participants we need to have accurate information on the items below.

Please put a check next to all conditions experienced within the last 5 years.

___ Hearing problems

___ Broken bones, dislocations

___ Vision (glasses, contacts, blindness)

___ Chest pains or cardiac irregularities

___ Dizzy spells, fainting, convulsions

___ Shortness of breath, asthma

___ Motion sickness

___ High blood pressure

___ Chronic pain (arthritis, muscle or joint stiffness)

___ Diabetes

___ Knee, shoulder, ankle or other joint problems

___ Neck or back problems

___ Stomach, kidney, bladder, other internal problems

___ Other _____

If you have answered yes to any of the questions above please explain below and include:

1. Does this condition result in restrictions in your ability to perform any task?
2. What are the specific symptoms that you experience with this condition?
3. How often do symptoms or the condition occur and how severe are they?

4. How do you care for the symptoms of this condition?

Do you have any other condition requiring the use of prescription drugs? If so, explain _____

Other medical difficulties or health concerns? _____

Have you been hospitalized in the last year? If so, explain _____

The above information is accurate to the best of my knowledge:

(Participant Signature)

(Date)

(Parent guardian signature- If participant is under 18)

(Date)

BSU OUTDOOR PROGRAM CONSENT TO TREATMENT

In the event that I should for any reason require any minor medical or surgical treatment and/or medication during the course of attendance at or participation in the trip in question, I authorize such physician or medical staff as the BSU Outdoor Program staff to appoint or designate, carry out the necessary treatment, or take me to the emergency room of the nearest hospital. I further authorize the hospital and its medical staff to provide treatment deemed necessary by them for my well-being.

(Participant Signature)

(Date)

(Parent guardian signature- If participant is under 18)

(Date)