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Annual Health and Medical Record

(Valid for 12 calendar months)

Medical Information

GREEN recommends that all members have annual medical evaluations by a certified and licensed health-care provider. In an effort to provide better care to those who may become ill or injured and to provide students and the staff with a better understanding of their own physical capabilities, GREEN has established minimum standards for providing medical information prior to participating in various activities. Those standards are offered below in one three-part medical form.

Part A is to be completed by **all GREEN Program participants**. Both parts are medical information required includes a current health history and list of medications.

Part B is to be completed and signed by a certified and licensed health-care provider—physician (MD, DO), nurse practitioner, or physician’s assistant as appropriate for your state. The level of activity ranges from what is normally expended at home or at school to strenuous activity such as hiking and backpacking. Other examples include kayaking, rafting, zip-lining, and wind surfing

Risk Factors

Based on the vast experience of the medical community, GREEN has identified that the following risk factors may define your participation in various outdoor adventures.

- Heart disease
- Excessive body weight
- Hypertension (high blood pressure)
- Diabetes
- Seizures
- Lack of appropriate immunizations
- Asthma
- Sleep disorders
- Allergies/anaphylaxis
- Muscular/skeletal injuries
- Psychological and emotional difficulties

Last Name: _____ **First Name:** _____
DOB: _____ **Emergency Contact No.:** _____

Allergies: _____

Part A

GENERAL INFORMATION

Age: _____ Male Female
 Address: _____
 City: _____ State: _____ Zip: _____
 Phone No.: _____ Email: _____
 Social Security No. (optional): _____
 Health/accident insurance company: _____
 Policy No.: _____

ATTACH A PHOTOCOPY OF BOTH SIDES OF INSURANCE CARD. IF FAMILY HAS NO MEDICAL INSURANCE, STATE "NONE."

In case of emergency, notify:

Name: _____
 Relationship: _____
 Address: _____

 Home phone: _____ Business phone: _____
 Cell phone: _____ Email Address: _____
 Alternate contact: _____ Alternate's phone _____

MEDICAL HISTORY

Are you now, or have you ever been diagnosed with or treated for any of the following:

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension (high blood pressure)	
		Heart disease (i.e., CHF, CAD, MI)	
		Stroke/TIA	
		Ear/sinus problems	
		Muscular/skeletal condition	
		Menstrual problems (women only)	
		Psychiatric/psychological and emotional difficulties	
		Learning disorders (i.e., ADHD, ADD)	
		Bleeding disorders	
		Fainting spells	
		Thyroid disease	
		Kidney disease	
		Sickle cell disease	
		Seizures	
		GI problems (i.e., abdominal, digestive)	
		Surgery	
		Serious injury	
		Other	

Allergies or Reactions To:
Medication:

Food, Plants, or Insect Bites:

Immunizations:

The following are recommended but not required by GREEN. Tetanus immunization must have been received within the last 10 years. If had disease, put "D" and the year. If immunized, check the "YES" box and enter the year received. (For more information about immunizations, as well as the immunization exemption form, see the Center for Disease Control and Prevention at <http://wwwnc.cdc.gov/travel/destinations/costa-rica.aspx>).

Yes	No	Date
		Routine
		Hepatitis A or immune globulin (IG)
		Hepatitis B
		Typhoid
		Malaria
		Other (i.e. HIB)
		Exemption to immunizations claimed.

MEDICATIONS

List all medications currently used. (If additional space is needed, please photocopy this part of the health form.) Inhalers and EpiPen information must be included, even if they are for occasional or emergency use only.

Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>	Medication _____ Strength _____ Frequency _____ Approximate date started _____ Reason for medication _____ Distribution approved by: _____ Parent signature _____ MD/DO, NP, or PA Signature _____ Temporary <input type="checkbox"/> Permanent <input type="checkbox"/>
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NOTE: Be sure to bring medications in the appropriate containers, and make sure that they are NOT expired, including inhalers and EpiPens. You SHOULD NOT STOP taking any maintenance medication.

Part B
PHYSICAL EXAMINATION

Height: _____ Weight: _____ % Body Fat (optional): _____
 Meets height/weight limits: Yes No Blood pressure: _____ Pulse: _____

Individuals desiring to participate in any high-adventure activity or event in which emergency evacuation would take longer than 30 minutes by ground transportation will not be permitted to do so if they exceed the height/weight limits as documented in the table on the following page or if during a physical exam their health care provider determines that they are not physically capable of participating in strenuous activities such as hiking, swimming or kayaking.

	Normal	Abnormal	Explain Any Abnormalities	Range of Mobility	Normal	Abnormal	Explain Any Abnormalities
Eyes				Knees (both)			
Ears				Ankles (both)			
Nose				Spine			
Throat							
Lungs				Other	Yes	No	
Heart				Contacts			
Abdomen				Dentures			
Genitalia				Braces			
Skin				Inguinal hernia			Explain
Emotional adjustment				Medical equipment (i.e., CPAP, oxygen)			
COMMENTS:							

I certify that I have reviewed the health history, examined the person, and approved this individual for participation in:

- Hiking
 Swimming/water activities
 Climbing
 Sports
 Horseback Riding
 Zip lining/heights
 Hot springs (water temperatures >90°F)
 Wilderness Treks
 Warm weather activity (>80°F)

Specify restrictions (if none, state N/A)

To Health Care Provider: Restricted approval includes:

- Uncontrolled heart disease, asthma, or hypertension.
- Uncontrolled psychiatric disorders.
- Poorly controlled diabetes.
- Orthopedic injuries not cleared by a physician.
- Newly diagnosed seizure events (within 6 months).

Health Care Provider printed name _____

Signature _____

Address _____

City, state, zip _____

Office phone _____

Date _____

Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance	Height (inches)	Recommended Weight (lbs)	Allowable Exception	Maximum Acceptance
60	97-138	139-166	166	70	132-188	189-226	226
61	101-143	144-172	172	71	136-194	195-233	233
62	104-148	149-178	178	72	140-199	200-239	239
63	107-152	153-183	183	73	144-205	206-246	246
64	111-157	158-189	189	74	148-210	211-252	252
65	114-162	163-195	195	75	152-216	217-260	260
66	118-167	168-201	201	76	156-222	223-267	267
67	121-172	173-207	207	77	160-228	229-274	274
68	125-178	179-214	214	78	164-234	235-281	281
69	129-185	186-220	220	79 & over	170-240	241-295	295

This table is based on the revised Dietary Guidelines for Americans from the U.S. Dept. of Agriculture and the Dept. of Health & Human Services.

This student meets the specified emergency evacuation requirements outlined in the table above.

Yes No

Statement of Consent:

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental attention to be administered to myself, in the event of an accidental injury or illness. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of local medical personnel.

Student Name

Date

Student Signature