32 Hope Road • Cranston, RI 02921 • 866-989-HIKE (4453)

Personal Health and Wellness Form

Purpose and Scope:

The purpose of this document is to ensure prompt and appropriate medical care in the event of an emergency. This document needs to be updated each year – it expires one year from the date signed by a medical provider, or adult signer (self or parent/guardian) if there is no medical provider signature. A medical provider (MD, DO, PA, or NP)* must sign the form if the participant is going to engage in strenuous or demanding activities – or any activity where the participants will be more than 30 minutes from emergency services. We defined included activities below. We recommend that a medical provider signs all completed forms. OAC, Inc is not a "covered entity" as defined by HIPAA. However, our medical privacy policy states that we place reasonable controls on personal medical information and destroy expired forms in a manner expected to provide adequate privacy.

Identification & Insurance

Name: _____ Date of Birth: _____ ☐ Male ☐ Female

Home Address: _____ City/State/ZIP: _____

Person(s) to contact in event of an emergency *(at least one should be a parent/guardian for a minor)*:

Name: _____ Relationship: _____ Telephone: (___) _____

Name: _____ Relationship: _____ Telephone: (___) _____

Health insurance carrier: _____ Policy No.: _____

General Medical Information

Allergies: _____

List all significant allergies (food/medicine/insects/plants) and describe typical reaction and treatment

List any medications you currently take (prescription/non-prescription) and dose/frequency: _____

_____

List any physical/mental/behavioral conditions that may affect participation in expected activities: _____

_____

List any other health-related conditions we should know about for your safe participation: _____

_____

Note: if anything above changes prior to an activity, ensure you provide an updated copy of this document to the leadership of the activity.

Name: _____ OAC Personal Health & Wellness Form

Date of Birth: _____ **Emergency Contact Phone Number:** _____

Medical History

Yes	No	Condition	Explain
		Asthma	
		Diabetes	
		Hypertension	
		Heart Disease	
		Stroke	
		Bleeding disorders	
		Seizures	
		Fainting spells	
		Sleep disorders	
		Social/psychological problems	
		Learning disabilities (e.g. ADHD)	
		Muscular-skeletal condition	
		Major surgery	
		Serious injury	
		Ear/sinus problems	
		GI problems (digestive, etc.)	
		Menstrual problems (women only)	
		Pregnancy (women only)	

Immunizations:

The following are recommended. Tetanus must have been received within the past 10 years. Enter date of last shot and place a 'D' next to the date if you had the disease.

Yes	No	Immunization	Date
		Diphtheria	
		Pertussis	
		Tetanus	
		Measles	
		Mumps	
		Rubella	
		Chicken Pox	
		Polio	
		Hepatitis A	
		Hepatitis B	
		Influenza	

Physicians Approval for Activities

Completion of this section is required only if the individual will be participating in the activities listed with an asterisk. We strongly recommend that individuals planning to participate in any of the listed activities consider consulting with a physician prior to participation. It is the responsibility of the individual, or their parent/guardian to ensure they are physically prepared for these activities, some of which may be intensely physical.

I certify that I have reviewed the health history, examined this individual, and approve their participation in the following activities:

☐ Backpacking
☐ Cycling
☐ Kayaking/canoeing
☐ Wilderness treks (>3 days)*
☐ Challenge courses (COPE)
☐ Mountain biking
☐ Cold weather activities (<10°F) *
☐ SCUBA diving*
☐ Whitewater rafting
☐ Hiking/camping
☐ Climbing/rappelling*
☐ Competitive sports
☐ Horseback riding
☐ Extreme Treks (20+ miles)*

Specify any restrictions on above activities. If none, state none: _____

Print physician's name: _____

Signature: _____

Address: _____

City, State, ZIP: _____

Office phone: _____

Date: _____

To physicians: Common restrictions include:

⇨ Uncontrolled heart disease or hypertension

⇨ Uncontrolled asthma

⇨ Uncontrolled psychiatric disorders

⇨ Poorly controlled diabetes

⇨ Uncleared orthopedic injuries

⇨ Seizures within last six months

⇨ SCUBA – any diabetes, asthma, or seizures