# SENIOR OUTDOOR REFLECTION TRIP (SORT) MEDICAL FORM, CONSENT, AND RELEASE

This form is used to provide information for medical personnel in the event of an illness, injury, or accident and to inform Harvard officers associated with SORT and program leaders of SORT of any physical condition that may impact your participation on a SORT trip. You must complete this form in order to participate on SORT. The form is due on April 21, 2017.

Name: _____

Birthdate: _____ Height: _____ Weight: _____ Body Mass Index: _____

Name of Physician: _____ Phone number: _____

Parent/guardian name: _____ Phone number: _____

Emergency contact: _____ Phone number: _____

## INSURANCE

Are you covered by the Harvard health insurance program? Yes ____ No ____

Medical insurance carrier: _____ Policy #: _____

Address: _____ Phone number: _____

Name of insured: _____ Relationship to member: _____

## GENERAL MEDICAL HISTORY

Do you currently have or have you ever had a history of any medical condition that could affect your ability to fully participate in a SORT trip or that would be important for medical workers to know about you if you became injured?

Yes ____ No ____

If Yes, please provide details of any pertinent medical condition: _____

_____

_____

| | | | |
|---|---|---|---|
| Respiratory Problems? Asthma? | Yes ____ No ____ | Bleeding or blood disorders? | Yes ____ No ____ |
| Hepatitis or other liver disorders? | Yes ____ No ____ | Cardiac problems? | Yes ____ No ____ |
| Heart Murmurs? | Yes ____ No ____ | High blood pressure? | Yes ____ No ____ |
| Chest pain with exertion | Yes ____ No ____ | Unexplained seizure? | Yes ____ No ____ |

Unexplained excessive fatigue with exertion? Yes ____ No ____

Dizziness or non-vasovagal fainting episodes with exertion? Yes ____ No ____

Clinically significant arrhythmias? Marfan's? Yes ____ No ____

Family history of disability from heart disease in a relative who is under the age of 50? Yes ____ No ____

Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? Yes ____ No ____

Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? Yes ____ No ____

## CURRENT MEDICATIONS

Are you currently taking any medications? Yes ____ No ____

If Yes, please specify dose. Medication Dosage (amount/frequency) For What Condition? Side Effects/Restrictions?

_____

_____

_____

## MUSCULAR/SKELETAL INJURIES

Many muscular/skeletal injuries may reoccur when under the physical stress of an outdoor trip. Please indicate (over)

**ANY** past histories with the following conditions:

- Knee, hip or ankle injuries (including sprains) and/or operations? Yes ____ No ____
- Shoulder, arm or back injuries (including sprains) and/or operations? Yes ____ No ____
- Any other joint problems? Yes ____ No ____

Specific comments (include date of last occurrence and the effect of the problem on current activity level):

_____

_____

**ALLERGIES/DIETARY RESTRICTIONS**

Do you have any allergies? Please list: _____

- Are you allergic to shellfish (iodine)? Yes ____ No ____
- Are you allergic to peanuts? Yes ____ No ____
- Are you allergic to any other foods? Yes ____ No ____
- Allergic to insect bites or bee stings? Yes ____ No ____

Specific comments: _____

_____

Allergic to any medications? (Please list and describe below) Yes ____ No ____

_____

**HEAT, COLD**

25. History of frostbite or Raynaud's Syndrome? Yes ____ No ____
26. History of heat stroke or other heat related illness? Yes ____ No ____
27. History of serious reaction to high or low temperatures? Yes ____ No ____

Specific comments: _____

_____

**OTHER MEDICAL CONDITIONS**

Do you have any other medical conditions that could affect your participation? Yes ____ No ____

_____

_____

**CONSENT AND RELEASE**

In signing this form, I certify that I have reviewed this form and that information is correct to the best of my knowledge. Should I require immediate first aid or other emergency care for an injury or illness, I hereby consent to receive necessary first aid or other emergency medical treatment.

I, on behalf of myself and anyone claiming through myself, do FOREVER RELEASE [the President and Fellows of Harvard College, its trustees, officers, members of its governing boards, employees, volunteers, agents and assigns (collectively, "Harvard")] from any cause of action, claims, or demands of any nature whatsoever, including but not limited to a claim of negligence which I or anyone claiming through myself may now or in the future have against Harvard on account of personal injury, bodily injury, death or accident of any kind, arising out of or in any way related to participation in the SORT program, howsoever the injury is caused.

I understand the above agreement and have had an opportunity to ask questions in regard to its terms and my obligations.

Your Signature: _____ Your Name:_____ Date: _____