Follow-up

Approval

Prescott College
FOR THE LIBERAL ARTS AND THE ENVIRONMENT

INSTRUCTIONS

Name ____ **Date** ____________________

All the questions on this form are important. The answers are needed in order to assess your level of participation in a Lifelong Learning Center adventure, field, and/or physical activity course. Please answer every question in every section and return the form as soon as possible, in order to allow time for any needed follow-up. Incomplete forms will slow down the screening process, and may prevent you from being able to participate in your course.

PART I General Information

PARTICIPANT

Name ____
Gender ☐ Male ☐ Female
Age _______ DOB ____/____/____
Address ___________________________________ Apt. ____
City/State/Zip ____

Daytime Telephone # (______)________________________
Evening Telephone # (______)________________________
FAX # (______)____________________________
email ______________________________
Do you speak/understand English? Yes ☐ No ☐

PARENT/GUARDIAN (if under 18)

Name ___________________________________
Home Telephone # (______)______________
Work Telephone # (______)______________
FAX # (______)___________ email __________________

EMERGENCY CONTACT

Name/Relationship ______________________________
Daytime Telephone # (______)________________________
Evening Telephone # (______)________________________
Cell Phone # (______)___________ email ______________________

FAMILY PHYSICIAN

Name _________________________________ Telephone # (______)______________ FAX # (____)______________

PART II Medical Information

A. Allergies (Including allergies to medicines, foods, insect bites/stings) **NONE ☐ or…**

Allergy	Reaction	Medication Required (if any)

B. Current Medications (Including psychiatric medication, over-the-counter medication, inhalers) **NONE ☐ or…**

Medication/Supplements	Taken For: (Symptom/Condition)	Dosage	Date Started	Current Side Effects

Prescott College recommends that all participants have a current tetanus immunization (within 10 years).

PART III Health Profile

#	Please √ one--If yes, describe below	Y	N	#	Please √ one--If yes, describe below	Y	N
1	Seizure within the past 1 year			6	Use of Tobacco/Smoker		
2	Hospitalization/Emergency Room/Urgent Care visit within the past 1 year			7	Current Neck/Back/Shoulder/Knee/Ankle/or other joint problem		
3	Asthma (If yes, please bring inhaler)			8	Currently Pregnant		
4	Unexplained chest pain/pressure, shortness of breath, rapid heartbeat, sweats, or exertional dizziness or faint spells			9	Diabetes/Hypoglycemia		
				10	Diagnosed Learning Disability and/or ADD/ADHD and/or current counseling or treatment with a therapist, psychiatrist, psychologist, or prescribing physician		
5	Other cardiac conditions, e.g., heart murmur or other rhythm abnormality			11	Other medical pre-existing conditions that could affect your participation in the course.		
Describe all YES answer listed above							

PART IV Cardiovascular Fitness Evaluation – REQUIRED INFORMATION!

A. Important! Background Information (We need this information to evaluate you for participation in your course.)

Blood Pressure must be taken within 6 months of course start. **You may take your own blood pressure using apparatus at local department or drug store.**	Age ______ Height _______ft. ________ins. Weight _________lbs. Blood Pressure Reading ________/________ Date Taken ______________ **IF BP is over 150/90, please take a second time:** Second BP Reading ________/_________ Date Taken ______________

B. Current Exercise Activity (Needed as important assessment tool)

Please list the activities you do on a daily or weekly basis which show your current fitness level. Be sure to include activities such as walking a pet, playing basketball, skateboarding, skiing, etc.

Activity	Frequency	Approximate Time/Distance	Leisurely	Moderately	Intensely

PART V Signature Required

Consent is hereby given for the participant to attend the course and permission is given for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary.

All information will remain confidential. You should know that over the years, many participants with a variety of medical/psychological challenges have successfully participated in our courses, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow participants.

____ _________________________

Participant's Signature **Date**

____ _________________________

Parent's/Guardian's Signature (if participant is under 18) **Date**