

**TOUCH OF NATURE ENVIRONMENTAL CENTER - SOUTHERN ILLINOIS UNIVERSITY AT CARBONDALE  
CONFIDENTIAL MEDICAL HISTORY**

**SPECTRUM WILDERNESS PROGRAM**

**PART I**

**PLEASE PRINT OR TYPE ALL INFORMATION**

Name: Last	First	Middle	Nickname	Date of Birth	Sex	Age	Social Security No.	
							____ - ____ - ____	
Home Address: Street or Rural	City	State	Zip	Telephone	Fax			
				( )	( )			
Business Address: Street or Rural	City	State	Zip	Telephone	Fax			
				( )	( )			
Parent, Legal Guardian, Spouse				Second Parent, Legal Guardian, Advocate				
Address: Street or Rural				City	State	Zip	Address: Street or Rural	
				City	State	Zip	City	
Telephone: ( )				Fax: ( )	Telephone: ( )			
				Fax: ( )				
If Not Available in Emergency, Notify:	Name:			Relationship:		Telephone : ( )		
Name of Family Physician				Office Telephone No.		Emergency Telephone No.		
				( )		( )		
Name of Dentist/Orthodontist				Office Telephone No.		Emergency Telephone No.		
				( )		( )		

**PART II:** If you have any of the following conditions, or are currently experiencing them, please put a check next to the number and give details at the end of this section. If you have questions about these statements, ask your physician.

- |   |   |
|---|---|
| <input type="checkbox"/> 1. Dizzy spells, fainting, convulsions, persistent headaches                                 | <input type="checkbox"/> 21. History of diabetes, thyroid trouble, bleeding problems.   |
| <input type="checkbox"/> 2. Motion sickness.  | <input type="checkbox"/> 22.* Currently on any medications. If so, what?  |
| <input type="checkbox"/> 3. Frequent infection of throat, tonsils, sinuses, etc.                                      | <input type="checkbox"/> 23. Claustrophobia, agoraphobia, acrophobia (fear of closed spaces, opens spaces or heights).                |
| <input type="checkbox"/> 4. Chronic cough, bronchitis, bloody sputum.   | <input type="checkbox"/> 24. Episodes of depression, anxiety, hysteria, nervousness or general psychiatric treatment.                 |
| <input type="checkbox"/> 5. Shortness of breath or asthma on exertion.  | <input type="checkbox"/> 25. Any problems with vision or hearing which requires hearing aid. Contact lenses ____.                     |
| <input type="checkbox"/> 6. Chest pains on exertion or deep breathing.  | <input type="checkbox"/> 26. Problems with teeth, use of dentures or bridge or recent oral surgery.                                   |
| <input type="checkbox"/> 7. Low or high blood pressure.   | <input type="checkbox"/> 27. Palpitation of the heart, irregular heart beat, heart murmurs, poor circulation or heart defect disease. |
| <input type="checkbox"/> 8. Jaundice or hepatitis.  | <input type="checkbox"/> 28. Frequent nausea or vomiting, food intolerances or heartburn.   |
| <input type="checkbox"/> 9. Frequent abdominal cramps. Severe menstrual cramps.                                       | <input type="checkbox"/> 29. Difficulty urinating, burning or pain on urination, frequency in urinating, bet-wetting.                 |
| <input type="checkbox"/> 10. Frequent diarrhea or blood in the stools.  | <input type="checkbox"/> 30. Broken bones, joint dislocation, serious sprains or weakness of muscles.                                 |
| <input type="checkbox"/> 11. Hernia.  | <input type="checkbox"/> 31. Severe illness requiring hospitalization or prolong incapacitation.                                      |
| <input type="checkbox"/> 12. Kidney infection or stones.  | <input type="checkbox"/> 32. Allergy to medications, foods, materials, insect bites, bee stings, plants, hayfever, etc.               |
| <input type="checkbox"/> 13. Chronic pain in the neck, back, shoulders, arms or legs.                                 | <input type="checkbox"/> 33. Bloodborne pathogens (HIV, Hepatitis, etc.).   |
| <input type="checkbox"/> 14. Joint pain, swelling or stiffness without injury.  |   |
| <input type="checkbox"/> 15. Any severe injury to head, chest, internal organs.                                       |   |
| <input type="checkbox"/> 16. Chronic skin problems (rash, infection).   |   |
| <input type="checkbox"/> 17. Reaction to extremes of temperature, frostbite.  |   |
| <input type="checkbox"/> 18. Continuing use of alcohol, drugs, medication.  |   |
| <input type="checkbox"/> 19. Special dietary requirements, e.g. vegetarian, macrobiotic or special food restrictions. |   |
| <input type="checkbox"/> 20. Convulsions.   |   |

(If you require a special diet, please explain in Part IV - Notes, and contact the Program for which you are registered **before** the program begins). If you have checked any of the items above, please list details below according to the item number. Be specific, e.g., include dates, names of medication, history of condition, etc.

Be sure to list Item Number(s) with your explanation:

\*If you have checked #22 and are using prescribed medication, bring an amount adequate for the length of the participation in the original containers with dosages. Did you list the medication above?

**(OVER)**

Has participant ever had a seizure [ ] yes [ ] no. If yes, the date of the last seizure: \_\_\_\_\_  
 What usually causes the seizure: \_\_\_\_\_  
 Describe the behavior before and after the seizure: \_\_\_\_\_  
 Females: Has participant menstruated? \_\_\_\_\_ What was the date of their last period? \_\_\_\_\_ Is the participant pregnant? \_\_\_\_\_  
 Please list any operations or serious injuries along with the date: \_\_\_\_\_

**PART III. IMMUNIZATION HISTORY** (To be completed by Physician from participant's medical records).  
 Required immunizations must be determined locally. List dates of basic immunizations and most recent booster dose.

Vaccines	Year of Basic Immunization	Year of Last Booster
Diphtheria	1.	1.
Pertussis (whooping cough) DPT	2.	3.
Tetanus	3.	

or

Tetanus TD
Diphtheria

or

Tetanus	Oral Polio (Sabin) TOPV
Injectable Polio (Salk)	Measles (hard measles, red measles, Rubeola)
Mumps	Rubella (German measles, 3-day measles)
Other	Tuberculin test given _____ (most recent)
Haemophilus influenza b (HIB)	HBV

**IMPORTANT: PLEASE NOTIFY THE PROGRAM COORDINATOR IF THIS PARTICIPANT WAS EXPOSED TO ANY COMMUNICABLE DISEASE DURING THE THREE WEEKS PRIOR TO ATTENDANCE.**

Health (Medical Insurance Carrier):	Policy/Group No.
Address:	IDPA Medical Card No.
Telephone Numbers:	

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**THIS SECTION MUST BE COMPLETED FOR ATTENDANCE**

This health history is correct as far as I know, and the person herein described has permission to engage in all activities except as noted.

**Authorization for Treatment:**

I hereby give permission for any emergency medical care which might become necessary in the event that may endanger the participants life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. I understand that the program includes physically and mentally strenuous activities in a wilderness setting, thereby necessitating this clause.

This release form is completed and signed of my own free will for the following specific purposes:

1. Authorization of medical treatment under emergency circumstances in my absence.
2. Authorization for the release of medical information deemed necessary for the filing of insurance claims for the medical treatment received for an injury and/or illness while attending a Touch of Nature program.
3. Acknowledgment that as a legal guardian, I am responsible for any expenses involving pre-existing or non-program related medical treatment or prescriptions.

A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL.

\_\_\_\_\_  
 Signature of Parent or Legal Guardian

\_\_\_\_\_  
 Date

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**PART IV: NOTES:** \_\_\_\_\_

\_\_\_\_\_