

FIRST NAME \_\_\_\_\_ MI: \_\_\_\_\_ LAST NAME \_\_\_\_\_

SISD# \_\_\_\_\_ PHONE AT BROWN \_\_\_\_\_ PHONE OVER SUMMER \_\_\_\_\_

AGE \_\_\_\_\_ SEX \_\_\_\_\_ WEIGHT \_\_\_\_\_ RESTING PULSE RATE: \_\_\_\_\_ DATE OF LAST PHYSICAL EXAM: \_\_\_\_\_

**CURRENT EXERCISE ACTIVITY:** Do you exercise regularly?  No  Yes

If yes, list any physical activities or sports you engage in, times per week, duration, and level of intensity.

| Activity | Times/Week | Approximate Time/Distance | Level of Intensity  |
|----------|------------|---------------------------|---|
|          |            |                           | <input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely |
|          |            |                           | <input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely |
|          |            |                           | <input type="checkbox"/> Leisurely <input type="checkbox"/> Moderately <input type="checkbox"/> Intensely |

**REQUIRED IMMUNIZATION:**

| Immunization | Required Interval   | Last Immunization Date | Exemption                          |
|--------------|---|------------------------|------------------------------------|
| Tetanus      | Within 10 years of September 2, 2009. Recommended within 5 years. |                        | <input type="checkbox"/> Religious |

**CURRENT HEALTH STATUS:** Please indicate if you have any and all medical conditions or physical disabilities that could interfere with or limit your participation in the trip. If you are unsure, explain the trip to your physician and ask for his/her advice. (*None of these will necessarily prohibit your participation, but for your own safety, we must be aware of such conditions.*) If you answer yes to any of the questions below, please specify in detail below, indicating the item number. All information is kept confidential. Attach additional sheets if necessary.

|   |  |   |  |
|---|--|---|--|
| 1. Hearing or Vision Problems (do <u>not</u> include wearing glasses or contacts) | <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Serious Reaction to High or Low Temperatures | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Respiratory Problems (do <u>not</u> include minor ones)                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Frequent Muscle Cramps?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Back Problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. High or Low Blood Sugar                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Joint Problems (e.g. knees, ankles, hips, etc.)                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Seizure Disorders                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Serious Illness or Hospitalizations in last year.                              | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Anemia, Bleeding tendencies or Traits       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Surgeries in last 6 months   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Psychological or Emotional Problems         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Heart Problems or High Blood Pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Other                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If there is any relevant medical information that we should know and have not asked, please provide this along with the detailed information for the checked items above.

| Item # | Detailed description (include restrictions, if any) |
|--------|---|
|        |   |
|        |   |
|        |   |

**ALLERGIES:** Please indicate all allergies you have (medications, foods, etc.), your allergic reactions, and any medication required.

| Allergies (check if applicable, write in others)               | Reaction | Medication Required (if any) |
|--|----------|------------------------------|
| Insect stings (bees, wasps, etc.) <input type="checkbox"/> Yes |          |                              |
| Iodine or Shellfish Allergy <input type="checkbox"/> Yes       |          |                              |
|  |          |                              |
|  |          |                              |

**DIETARY RESTRICTIONS OR FOOD ALLERGIES:** (Vegetarian, Kosher, lactose intolerant, etc., please indicate specific dietary restrictions.)

|  |
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|  |
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|  |

**MEDICATIONS:** Please indicate all medications you are currently taking, for what condition, and whether you will need to take it during the trip. *If you need to take medication during the trip, be sure you have an ample supply.*

| Medication | Condition | Do you need this during the trip?                        |
|------------|-----------|--|
|            |           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|            |           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|            |           | <input type="checkbox"/> Yes <input type="checkbox"/> No |

| PRIMARY PHYSICIAN(S) CONTACT INFORMATION |                 |
|--|-----------------|
| Family Physician:                        | Business Phone: |
| Address:                                 |                 |

| EMERGENCY CONTACT PERSON(S): |                 |
|------------------------------|-----------------|
| Name:                        | Relationship:   |
| Address:                     | Home Phone:     |
|                              | Business Phone: |
| Name:                        | Relationship:   |
| Address:                     | Home Phone:     |
|                              | Business Phone: |

| INSURANCE INFORMATION  |                 |
|------------------------|-----------------|
| Insurance Company Name | Policy Number:  |
| Insurance Policy Name: | Home Phone:     |
|                        | Business Phone: |

**AUTHORIZATION FOR EMERGENCY MEDICAL CARE**

1. I am aware of my past and present health and fitness for doing strenuous activity. I will participate in all program activities, except for those noted on this form by myself and/or my physician. Information about any and all prescription drugs that I am currently taking is noted on this form. I have completed this form to the best of my ability with full knowledge that any information withheld may increase the potential for serious injury or reinjury.
2. Should an accident or emergency occur that renders me unable to communicate, I hereby give permission to the physician selected by BOLT staff to hospitalize and/or secure proper treatment for me, except as noted on this form.
3. The BOLT program reviews all medical forms and consults with Health Services regarding the information provided during this review process. Medical information will be kept confidential, but will be shared with necessary individuals including the BOLT Professional Staff, Brown Health Services staff, and relevant BOLT Leaders.
4. The BOLT program reserves the right to limit and refuse participation in its programs based on information submitted on this form. Health Services has the final say on medical decisions regarding participation.

Signature of Student \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

**FOR SIGNATURE OF PARENTS/GUARDIANS OF PARTICIPANTS UNDER 18**

I have been informed of and understand the nature of the activity in which my son/daughter/ward wishes to participate. Additionally, I have read the above statements and do hereby agree to release, indemnify, and hold harmless Brown University, including the Corporation, its Trustees, faculty, employees, staff, and other agents of and against any and all legal responsibilities during, arising out of, or in any way associated, directly or indirectly, with his/her participation in the program as stated above.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date