OUT There Adventures
608-772-2883
www.outthereadventures.org
info@outthereadventures.org

Nutritional Survey

Is the participant: _____ Vegetarian _____ Vegan _____ Gluten Free

Brief description of participant's current diet:

Food allergies: **YES** or **NO.** If yes, please explain:

Foods participant does not eat:

Does participant eat: ____ Breakfast ____ Lunch ____ Dinner ____ Snacks

Does participant have a medical condition that would warrant a special diet? **YES** or **NO.** If yes, please explain:

Does participant have any eating disorders? **YES** or **NO.** If yes, please explain:

Medical Release

Participant Name: _____DOB: _____

This form will remain private and will not be shared with any individual or agency, unless an emergency arises and this information is needed for emergency medical services. This information may be used in a court of law if needed to indemnify OUT There Adventures against allegations of negligence or wrongdoing.

Emergency Contact

1) Name _____

Relation _____

Phone (_____)_____

Phone (_____)_____

2) Name _____

Relation _____

Phone (_____)_____

Phone (_____)_____

Medications

OTA staff hold and dispense any prescription or non-prescription medication that a participant under the age of 18 may need. It is critical that OTA staff have accurate information about each medication that participant takes as well as adequate medication to last them until the last day of each adventure. Please confirm the following medication with a physician prior to the first day of the trip.

Medication: _____ Reason: _____Dosage: _____

Schedule: _____ Quantity per day: _____

Medication: _____ Reason: _____Dosage: _____

Schedule: _____ Quantity per day: _____

Medication: _____ Reason: _____Dosage: _____

Schedule: _____ Quantity per day: _____

Medication: _____ Reason: _____Dosage: _____

Schedule: _____ Quantity per day: _____

Medication: _____ Reason: _____Dosage: _____

Schedule: _____ Quantity per day: _____

Medication: _____ Reason: _____Dosage: _____

Schedule: _____ Quantity per day: _____

Participant Medical Information

Please circle **YES** or **NO** appropriately any of the following problems the participant has currently or has had previously.

Broken Bones **YES** or **NO**

Dislocations **YES** or **NO**

Liver/Kidney Problems **YES** or **NO**

Lack of bowel or bladder control **YES** or **NO**

Ulcers **YES** or **NO**

Heart Trouble **YES** or **NO**

Rheumatic Fever **YES** or **NO**

Epilepsy **YES** or **NO**

Diabetes **YES** or **NO**

Pregnancy **YES** or **NO**

Eating Disorders **YES** or **NO**

Substance Abuse **YES** or **NO**

Depression **YES** or **NO**

Schizophrenia **YES** or **NO**

Other Mental Health Issues **YES** or **NO**

Current Tetanus **YES** or **NO**

Tuberculosis **YES** or **NO**

Infectious Diseases **YES** or **NO**

Skin Infections **YES** or **NO**

Hepatitis **YES** or **NO**

Thyroid Issues **YES** or **NO**

Operations **YES** or **NO**

Describe each problem marked **YES** (below and on back if necessary) and how it is or was being handled.

_____

_____

_____

_____

_____

_____
_____
_____
_____
_____
_____

We are particularly concerned about any kind of heart irregularities, which can be fatal in combination with high exercise levels, weather extremes, and the use of some kinds of street drugs. The following indicators may suggest cardiac problems in young people:

- Has the participant ever passed out during or after exercise? **YES** or **NO**
- Has the participant ever been dizzy during or after exercise? **YES** or **NO**
- Has the participant ever had chest pain during or after exercise? **YES** or **NO**
- Has the participant ever had high blood pressure or cholesterol? **YES** or **NO**
- Has the participant ever been told they have a heart murmur? **YES** or **NO**
- Has the participant had a viral infection (myocarditis or mononucleosis in the last 30 days? **YES** or **NO**
    - Within the last year? **YES** or **NO**
- Has any physician ever restricted participation in sports for heart problems?

  YES or **NO**

Medical History

Have you had any muscular or skeletal conditions (joints, back, surgeries, etc.) that may affect your ability to participate with OUT There Adventures?

YES or **NO**

If YES, please explain: _____

_____

_____

Do you have any medical condition that OUT There Adventures needs to be aware of, such as diabetes or asthma? Do you require any medications to maintain these conditions?

YES or **NO**

If YES, please explain: _____

_____

_____

Do you have any allergies to medicine, bee stings, food, or other? If yes, describe EXACTLY what causes them, what the reactions are, the seriousness, and what countermeasures or medications are necessary.

YES or **NO**

If YES, please explain: _____

_____

_____

Do you have a heart condition? Have you ever had a heart attack?

YES or **NO**

If YES, please explain: _____

_____

_____

Are there any other health problems of which you are aware? If so, please describe: _____

_____

_____

_____

Does the participant have any sulfa-drug allergies? **YES** or **NO**

Does the participant have any penicillin allergies? **YES** or **NO**

Does the participant have any shellfish/iodine allergies? **YES** or **NO**

Drug and Alcohol Policy

At no time while participating with OUT There Adventures will any participant be under the influence or drugs or alcohol or take any substance that may otherwise impair your ability to function at a normal and reasonable level. OUT There Adventures reserves the right to terminate activities if the participant is under the influence.

Participant Initials: _____

Physical Disclaimer

OUT There Adventures' programs and activities are strenuous and require a reasonable level of fitness and athleticism to participate. Related activities include hiking distances uphill, carrying equipment, and moving over uneven terrain. The participant should be realistic with what they are able to do and OUT There Adventures is not responsible for the participant's level of preparedness for the activity.

Participant Initials: _____

Medication Disclaimer

The use of over-the-counter medication, such as acetaminophen, ibuprofen, aspirin and other over-the-counter medicine is solely the choice of the participant and I (print name) _____ accept responsibility for the use of any over-the-counter medicine regardless of the source of medicine.

Participant Initials: _____

I (print name) _____ have read this form and have completed the medical information to the best of my knowledge, and I am solely responsible for providing accurate information to OUT There Adventures.

Signature _____ Date _____

Signature of Guardian if under 18 years of age.

Signature _____ Date _____