



**APPALACHIAN
MTN CLUB**

**Appalachian Mountain Club
Confidential Health Questionnaire**

Participant Name: _____
First Middle Last

Program Name: _____ **Program Start Date:** _____

Birthday: _____ **Height:** _____ **Weight:** _____ **Gender:** _____
Month/Day/Year

Home Address: _____
Street City State Zip code

Phone #s: _____
Day Evening Cell

Emergency Contact: _____
Name Relationship

Emergency Contact's Phone #s: _____
Day Evening Cell

HEALTH QUESTIONNAIRE

Parent or legal guardian should complete form for all children under 18 years participating in AMC program.

1. Have you experienced an asthma attack at any time in your life? Yes No

If Yes: Will you be carrying your inhaler on the program? _____
How often do you use your inhaler to treat asthma or wheezing? _____

2. Have you ever been diagnosed with type I or type II diabetes? Yes No

If Yes: Do you have poor or reduced circulation due to your diabetes? _____
Will you be carrying insulin or wearing an insulin pump during the program? _____

3. Have you ever experienced a serious allergic reaction, or have you ever been given a shot of epinephrine for an allergy or anaphylaxis? Yes No

If Yes: What are you allergic to and how does your body typically respond when exposed? (e.g. bee sting → hives) _____
Will you be carrying or bringing epinephrine on the program? _____

4. Have you ever experienced or received medical treatment for angina, a heart attack, or any type of heart disorder/disease? Yes No

If Yes: Are you able to exert yourself for more than 30 minutes without experiencing angina (chest pain)? _____

5. Have you ever been diagnosed with or are you currently being treated for high blood pressure? Yes No

If Yes: Is your blood pressure currently under control (i.e. systolic under 140 and diastolic between 60 and 100)? _____

6. Have you ever experienced a seizure, or are you currently being treated for any type of seizure disorder? Yes No

If Yes: Are you currently taking medication for your seizures? _____
Have you experienced a seizure within the past year? _____

7. Is there anything else you think we should know about your medical background? (i.e., anything that could affect your safety or ability to participate fully?) Yes No

DIETARY RESTRICTIONS: Do you have any dietary restrictions? Yes – list below No

Please be specific: (food allergies, iodine/seafood allergy, vegetarian, no red meat, vegan, lactose intolerant, strong food dislikes, etc.) _____

PLEASE READ CAREFULLY! Participants (or parents/guardians, if appropriate) must read and sign below.

Participant acknowledgement of accuracy and understanding. By signing this form, I am declaring that, to the best of my knowledge, I have completed the questionnaire accurately. I also understand that by knowingly filling out the form inaccurately, or by withholding pertinent information about my health, I could potentially be increasing the risk to myself or others.

Consent to accept aid. By signing this form, I am giving consent and permission for AMC staff, volunteers, representatives, or contractors to provide medical care to me or to my child, to transport me or my child to a medical facility or to seek the aid of emergency medical services as deemed appropriate. I further authorize AMC staff, volunteers, representatives, or contractors to render whatever treatment they consider necessary for my or my child's health, and I agree to pay all costs associated with that care and transportation.

Participant's name (printed)

Participant's signature

Signature of parent/guardian (if applicant is under 18)

Date