



## 2008 Health Form

The thorough completion of this form is **mandatory** for participation in all SPLORE programs. This information will better prepare our staff to serve you safely and to respond professionally in the event of an emergency.

### **PARTICIPANT INFORMATION**

Name of Participant: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Agency (if applicable): \_\_\_\_\_ Date of Program: \_\_\_\_\_

Address: _____	City/State/Zip: _____
Phone Number: Home _____	Work: _____
Cell: _____	Fax: _____
E-mail: _____	

**Please check the ONE box that best describes your primary role on this program.**

<input type="checkbox"/> Participant with a disability	<input type="checkbox"/> SPLORE Volunteer Guide
<input type="checkbox"/> Agency Staff Member	<input type="checkbox"/> SPLORE Staff/AmeriCorps/Intern
<input type="checkbox"/> Personal Care Provider of a person with a disability	<input type="checkbox"/> Public School Student without a disability
<input type="checkbox"/> Family/Friend of a participant with a disability	<input type="checkbox"/> Other participant without a disability, describe: _____
<input type="checkbox"/> Fundraising Trip Participant	_____
<input type="checkbox"/> SPLORE Volunteer	_____

Age: _____	Date of Birth: _____
Gender: Male _____	Female _____
Approximate Height: _____	
Approximate Weight: _____	

<b>Race / Ethnicity:</b>	
<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian
<input type="checkbox"/> African American	<input type="checkbox"/> Native American
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other

### **EMERGENCY INFORMATION**

Health insurance company \_\_\_\_\_ Policy # \_\_\_\_\_

Physician \_\_\_\_\_ Physician Phone ( ) \_\_\_\_\_

Relative or close friend \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Day ( ) \_\_\_\_\_ Eve ( ) \_\_\_\_\_

### **PHOTO / VIDEO RELEASE**

Initial Here

I authorize SPLORE and other approved parties to use any photographs, video tapes, film, or audio of my participation in SPLORE programs for marketing/fundraising and business purchases.

**\*\*Participants under the age of 18 must have parent or legal guardian initial this statement\*\***

**DISABILITY INFORMATION**  
**Attach additional information if necessary**

**What is your Primary Diagnosis (if applicable) :** \_\_\_\_\_

Please check all boxes that apply to your disability/medical condition/special needs

- |   |   |
|---|---|
| <input type="checkbox"/> ADD/ADHD                                 | <input type="checkbox"/> Hearing Impairment/Deaf          |
| <input type="checkbox"/> Allergy to bee sting                     | <input type="checkbox"/> Heart Disease/Defect             |
| <input type="checkbox"/> Allergy to penicillin                    | <input type="checkbox"/> Hemiplegia : affected side _____ |
| <input type="checkbox"/> Amputation : Location: _____             | <input type="checkbox"/> HIV/AIDS                         |
| <input type="checkbox"/> Arthritis                                | <input type="checkbox"/> Low Vision/Blind                 |
| <input type="checkbox"/> Asthma                                   | <input type="checkbox"/> Lung Disease                     |
| <input type="checkbox"/> Autism                                   | <input type="checkbox"/> Mental Illness                   |
| <input type="checkbox"/> Back condition                           | <input type="checkbox"/> Multiple Sclerosis               |
| <input type="checkbox"/> Balance difficulties                     | <input type="checkbox"/> Muscular Dystrophy               |
| <input type="checkbox"/> Behavioral Disorder                      | <input type="checkbox"/> Paraplegia                       |
| <input type="checkbox"/> Bipolar                                  | <input type="checkbox"/> Processing Delay                 |
| <input type="checkbox"/> Bowel/Bladder control problems           | <input type="checkbox"/> Recent Surgery                   |
| <input type="checkbox"/> Cancer                                   | <input type="checkbox"/> Quadriplegia                     |
| <input type="checkbox"/> Cerebral Palsy                           | <input type="checkbox"/> Seizure Disorder/Epilepsy        |
| <input type="checkbox"/> Spinal Cord Injury : Injury Level: _____ | <input type="checkbox"/> Skin Breakdown/Decubitus Ulcers  |
| <input type="checkbox"/> Chemical dependency                      | <input type="checkbox"/> Special Medical Concern          |
| <input type="checkbox"/> Communicable diseases                    | <input type="checkbox"/> Spina Bifida                     |
| <input type="checkbox"/> Depression                               | <input type="checkbox"/> Stroke                           |
| <input type="checkbox"/> Developmental Disability                 | <input type="checkbox"/> TBI/Head Injury                  |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Youth In Treatment               |
| <input type="checkbox"/> Down Syndrome                            | <input type="checkbox"/> Other: _____                     |
| <input type="checkbox"/> Dysreflexia                              |   |

**Please use this space to expand upon information above and to add any other medical condition for which you are currently under treatment:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DIETARY INFORMATION**  
**Attach additional information if necessary**

- I have a special diet (please explain:) \_\_\_\_\_
- I have food allergies to the following items: \_\_\_\_\_
- I am a vegetarian: \_\_\_\_\_

**MEDICATION**  
**Attach additional information if necessary**

Name of Medication	Dose / Frequency	Reason for taking it	Side Effects

**MOBILITY**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> I use a manual w/c | <input type="checkbox"/> I have problems with balance         | <input type="checkbox"/> I have a prosthetic limb   |
| <input type="checkbox"/> I use a power w/c  | <input type="checkbox"/> I cannot sit up without back support | <input type="checkbox"/> I can walk with assistance |

**Please describe the way that you usually transfer in/out of your wheelchair, if applicable:**

\_\_\_\_\_

\_\_\_\_\_

**LIFE STYLE / BEHAVIOR ASSESSMENT**

**How would you describe your current activity level?**    sedentary    routine exercise    athlete

**What type of activities does this include:** \_\_\_\_\_

**Do you have anxiety regarding the SPLORE trip?** \_\_\_\_\_ **Do you usually experience anxiety in specific situations?** \_\_\_\_\_

**ADDITIONAL SAFETY INFORMATION**

**The following questions are used to gather information to enhance the safety of SPLORE programs. Although each question may not apply to all SPLORE activities, please answer the following information in its entirety.**

Please answer the following questions:	YES	NO
Are you capable of swimming independently?		
Are you capable of hiking independently?		
Are you capable of independently lifting your arms above your head?		
Are you capable of independently rolling over when face down in water?		
Are you capable of independently grasping a rope?		
Are you capable of physically signaling for help?		
Are you capable of yelling for help?		
Are you more sensitive to hot or cold temperatures than other people?		
Are you extra sensitive to the sun?		
Have you been on an overnight camping trip in your current state of health?		
Have you participated in any of the following activities in your current state of health:		
Canoeing?		
Rock Climbing?		
Whitewater Rafting?		
Skiing / Snowshoeing?		

**IMPORTANT!**

Please bring this completed form with you **ON THE DAY** of your activity and hand it to a SPLORE staff member.

**Thanks!**  
**See You Out There!**