



## 2009 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,<br>describe: _____ |
| <input type="checkbox"/> Fundraising Trip Participant                         | _____   |
| <input type="checkbox"/> SPLORE Volunteer                                     | _____   |

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Approximate Height: \_\_\_\_\_

Approximate Weight: \_\_\_\_\_

#### **Race / Ethnicity:**

- |   |  |
|---|--|
| <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!**

## PARTICIPANT AGREEMENT, RELEASE AND ASSUMPTION OF RISK

In consideration of the services of SPLORE, their agents, officers, volunteers, participants, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as "SPLORE"), I hereby agree to release, indemnify, and discharge SPLORE, on behalf of myself, my spouse, my children, my parents, my heirs, assigns, personal representative and estate as follows:

1. I expressly acknowledge that participation in SPLORE outdoor activities such as rock climbing, river rafting, canoeing and cross country skiing entails known and unanticipated risks that could result in physical or emotional injury, paralysis, death, or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity. The risks include, among other things: slipping and falling; falling objects; water hazards; exhaustion; exposure to temperature and weather extremes which could cause hypothermia, hyperthermia (heat related illnesses), heat exhaustion, sunburn, dehydration; exposure to potentially dangerous wild animals, insect bites, hazardous plant life; equipment malfunction or failure; accidental drowning; and improper lifting or carrying.

2. I expressly recognize and acknowledge and accept that SPLORE staff and volunteers have difficult jobs to perform during outdoor activities; that they seek safety, but they are not infallible; that they might be unaware of or misjudge a participant's fitness, awareness, weight or abilities; that they might misjudge the weather or other environmental conditions; and that they may give incomplete warnings or instructions; and the equipment being used might fail or malfunction.

3. I expressly agree and accept and assume all of the risks existing in this activity. My participation in this activity is purely voluntary, and I elect to participate in spite of the risks.

4. I hereby voluntarily release, forever discharge, and agree to indemnify and hold SPLORE harmless from any and all claims, demands, or causes of action, which are in any way connected with my participation in this activity or my use of SPLORE's equipment or facilities, including any such claims which allege negligent acts or omissions of SPLORE.

5. Should SPLORE or anyone acting on their behalf, be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs.

6. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating, or else I agree to bear the costs of such injury or damage myself. I further certify that I am willing to assume the risk of any medical or physical conditions I may have.

7. In the event that I file a lawsuit against SPLORE, I agree to do so solely in the state of Utah, and I further agree that the substantive law of Utah shall apply in that action without regard to the conflict of law rules of that state. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect.

By signing this document, I acknowledge that if anyone is hurt or property is damaged during my participation in this activity, I may be found by a court of law to have waived my right to maintain a lawsuit against SPLORE on the basis of any claim from which I have released them herein.

I have had sufficient opportunity to read this entire document. I have read and understood it, and I agree to be bound by its terms.

Signature of Participant \_\_\_\_\_ Print Name \_\_\_\_\_  
Address \_\_\_\_\_ City State Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Date \_\_\_\_\_

### PARENT'S OR GUARDIAN'S ADDITIONAL INDEMNIFICATION

(Must be completed for participants under the age of 18)

In consideration of \_\_\_\_\_ (print minor's name) ("Minor") being permitted by SPLORE to participate in its activities and to use its equipment and facilities, I further agree to indemnify and hold SPLORE harmless from any and all claims which are brought by, or on behalf of Minor, and which are in any way connected with such use or participation by Minor, specifically including but not limited to any claims associated with youth participation in rafting trips. I have been informed of the risks associated with youth participation in SPLORE activities and recognize them and acknowledge them and hereby knowingly accept them.

Signature of Parent or Guardian: \_\_\_\_\_ Print Name: \_\_\_\_\_