**The Honors College Medical Information Release Form**

Western Carolina University

Please fill out every item below as accurately and truthfully as possible. Provide details for any significant conditions, injuries, and/or illnesses that may affect your ability to participate with the Honors College. This form is the property of the Honors College and will remain as a confidential record to the fullest extent permitted by law for the excursion that you participate in. Only the instructors and medical personnel have access to this information.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

College Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Female or Male

Home Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In case of emergency, please contact:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Doctor’s Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the participant covered by medical insurance? YES or NO

Medical Insurance Company:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**------------------------------------------------------------------------------------------------------------**

1. If over age 35, what is your current Blood Pressure: \_\_\_\_\_\_\_\_\_\_\_\_ Date last checked: \_\_\_\_\_\_\_\_\_\_\_\_

a. Do you have any known heart conditions and/or high blood pressure? YES or NO **\*\***

b. Are you taking any medication for this condition? YES or NO

 If YES, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Are you Pregnant? YES or NO If YES, how far along? \_\_\_\_\_ **\*\***

**\*\* If you answered yes to questions 1 or 2, please consult your physician concerning your participation in this Honors College excursion. Please Note: The Honors College does not provide medical insurance for participants.**

3. Are you currently under other Physician Orders for medication or treatment? YES or NO

4. Will you bring these medications with you when you participate in our program? YES or NO

5. Are you allergic to insect stings, poison ivy, foods, drugs or other things? YES or NO

6. **Please circle any of the following conditions that pertain to you.**

a. Diet or Eating Disorders

b. Respiratory Conditions

c. Asthma

d. Physical Disabilities

e. Past Injuries/Illnesses

f. Neck/Spine/Back Problems

g. Fractures

h. Diabetes

i. Epilepsy/Convulsions

j. Past Operations

k. Other Medications

l. Other

**If you answered YES to questions 3, 4, 5, or circled a condition from the above list, please:**

list the medications, dosage and the frequency with which these are taken;

Describe specific allergies, your symptoms, the frequency of occurrence, how you care for the condition

and how this condition restricts your activity in any way; and/or describe all information, including specific symptoms, how long the symptom/condition lasts, frequency of occurrence, how you care for the symptom/condition, and how the condition restricts your activity in any way.

Use additional paper if necessary.

**Authorization for Emergency Medical Care: Should an accident or emergency occur, I hereby give permission to the Hospital Emergency Room physician to hospitalize and/or secure proper medical treatment for me, except as noted below. I agree to hold only myself liable for these noted exceptions.**

**EXCEPTIONS FOR TREATMENT/HOSPITALIZATION:**

Signature Date

Name (Please Print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Guardian (if under 18 years old)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_