

**Appalachian Mountain Club  
August Camp Confidential Health Questionnaire**

Participant Name: \_\_\_\_\_ Weeks Attending: \_\_\_\_\_

Age at Camp Attendance: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Home Address: \_\_\_\_\_  
City State Zip

Emergency Contact(s): \_\_\_\_\_ Primary Emergency Phone Number: (day) \_\_\_\_\_  
 (eve): \_\_\_\_\_

Emergency Cell Phone/Page: \_\_\_\_\_

Relationship of Emergency Contact(s): \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**SEVEN-QUESTION HEALTH QUESTIONNAIRE**

**Parent or legal guardian should complete form for their minor child participating in AMC activity.**

	Yes	No
<b>1. Have you experienced an asthma attack at any time in your life?</b> (Asthma can potentially be affected by exercising at altitude, in dry air, extreme cold, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. Have you ever been diagnosed with type I or type II diabetes?</b> (A diabetic can easily become dehydrated in backcountry environments. Further, long, arduous days/hikes can lead to hypoglycemia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>3. Have you ever visited a medical professional for a serious allergic reaction, or have you ever been given a shot of epinephrine for an allergy or anaphylaxis?</b> (Some people are allergic to stinging insects; nut products or other food products which a co-participant might be carrying or may be included in a meal prepared by AMC staff; iodine, which might be used to treat drinking water and/or clean wounds, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>4. Have you ever received medical treatment for angina, a heart attack, or any type of heart disorder/disease?</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>5. Have you ever been diagnosed with or are you currently being treated for high blood pressure?</b> (The environment and workload associated with August Camp can potentially affect BP and/or the efficiency of some BP medications.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>6. Have you ever seen a medical professional following a seizure, or are you currently being treated for any type of seizure disorder?</b> (Some seizures are triggered by fatigue and dehydration [which can occur following a long hike], significant change in diet, stress, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. Is there anything else you think we should know about your medical Background?</b> (i.e., anything that could affect your safety or ability to participate fully?)	<input type="checkbox"/>	<input type="checkbox"/>

**Food allergies (Please indicate the type and severity of reaction):**

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If you answered **YES** to **ANY** of the above questions please answer the following as well:

- I was diagnosed with \_\_\_\_\_ in the last year.
- I have visited the emergency room in the last year due to \_\_\_\_\_.
- I have had to use epinephrine following an asthma attack/allergies or anaphylaxis in the last year?
  - Will you be bringing/carrying epinephrine on the outing? \_\_\_\_\_
  - What are you allergic to? \_\_\_\_\_
- How often do you use your inhaler to treat your asthma or wheezing? \_\_\_\_\_
- Do you have poor circulation due to your diabetes? \_\_\_\_\_
- Will you be carrying insulin or wearing an insulin pump during your outing? \_\_\_\_\_
- Are you able to exert yourself for more than 30 minutes without experiencing angina (chest) pain?  
\_\_\_\_\_
- Are you currently taking medication for your seizures? \_\_\_\_\_
- Have you experienced a seizure within the past year? \_\_\_\_\_
- Is your blood pressure currently under control (i.e., systolic under 140 and diastolic between 60 and 100)? \_\_\_\_\_ Date you had your blood pressure tested by a health care provider? \_\_\_\_\_
- When was the last time you had a physical exam? \_\_\_\_\_

If there is anything else you think we should know about your medical background, please explain here. Attach a separate sheet if necessary.

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**PLEASE READ CAREFULLY! Participants (and 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