Rocky Mountain May Trip

MEDICAL CONSENT, RELEASE AND ASSUMPTION OF RISK

PARTICIPANT'S NAME____

As used herein: "Field Study Directors" shall include University of Saint Francis, their teachers, agents, employees and licensees, and "UNDERSIGNED" shall be the father and/or mother, or the guardian of the PARTICIPANT, or the PARTICIPANT if eighteen years of age or older.

The UNDERSIGNED understands that during the field study under the direction of the FIELD STUDY DIRECTORS, certain risks and dangers may occur, including, but not limited to hazards of accidents or illness in remote places without medical facilities, the forces of nature, and travel by airplane, automobile, bus, train, or by other conveyance. Field Studies and back packing are very strenuous activities. We plan to spend several days hiking in the Appalachian and in remote mountain areas. Hikers have been severely injured and died because of lack of preparation and overextending their physical limitations. We must have accurate information on your physical condition. Most conditions will not prevent you from participating in the program, but will help us assign hiking routes and clusters.

In consideration of the right to participate in this field study and related activities and to utilize the services, including food, as provided, the UNDERSIGNED hereby assume all the risks set forth above and hereby hold the FIELD STUDY DIRECTORS harmless from any and all liability, actions, causes of actions, debts, claims, and demands of every kind and nature whatsoever which arise from or in connection with the above described field study and related activities. The terms hereof shall serve as a release and assumption of risks for the UNDERSIGNED, his or her heirs, executors, administrators, and members of the UNDERSIGNED'S family.

In the event emergency medical treatment is required for the participant while participant is under the control and direction of the FIELD STUDY DIRECTORS and if consent is a requisite to any such treatment, the UNDERSIGNED hereby grant to the FIELD STUDY DIRECTORS the right to give consent for such treatment for the participant on behalf of the UNDERSIGNED. Said consent may be granted or withheld by the FIELD STUDY DIRECTORS as each of them in their sole discretion, shall determine. The UNDERSIGNED hereby waive claim they may have against the FIELD STUDY DIRECTORS arising from the granting or withholding of the aforesaid consent.

In the event that emergency medical treatment is provided to the PARTICIPANT, the UNDERSIGNED hereby authorizes any entity providing medical services or material in conjunction with emergency medical treatment, to seek payment for said services or material and assigns any medical insurance benefit for same services from the following insurers of the PARTICIPANT:

INSURER NAME:___________________ POLICY NUMBER_______________________

The UNDERSIGNED hereby guarantees payment of any medical insurance deductible, any service not covered by PARTICIPANT'S insurer, or any other cost incurred in providing emergency medical treatment to any entity providing or paying for medical services or material in conjunction with emergency medical treatment.

MEDICAL HISTORY FORM

NAME ____SEX________
ADDRESS ____
CITY_____________________ STATE______________________________ZIP___________________
HOME PHONE_____________________________ BUSINESS PHONE_____________________
HEIGHT______________ WEIGHT__________________ BIRTHDATE______________________
EMERGENCY CONTACT___________________________RELATIONSHIP_________________
ADDRESS____
PHONE (DAY)_____________________(EVENING)_______________________________________

MEDICAL INFORMATION

Are you more than 30% over the suggested body weight for someone of your height and gender (refer to the chart provided) Yes _____ No _____

Are you under the care of a physician or know of any chronic conditions which could affect your participation in this program including: _____ asthma, _____ exercise induced asthma, _____ anemia, _____ diabetes, _____heart problems, _____ foot trouble, _____ physical impairments or disability that might affect your ability to participate in this program. (list them)

If you have answered yes or checked any of the above, you will need to provide written physician approval to participate.

INDICATE IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

_____hearing difficulty _____dizziness _____claustrophobia _____high blood pressure _____ear infections _____fear of heights _____nausea _____headaches _____sun poisoning _____vomiting _____trouble breathing through your nose, except with a cold _____frequent upset stomach, heartburn, indigestion, ulcer _____nervous breakdowns or periods of marked depression

List any allergies:

List any medications you are currently taking:

Have you had surgery within the last year? If so, what?
Date of last tetanus shot or booster_________________________________

Indicate any other special considerations, such as reactions to medications, which we should be aware of. Are you taking medications that could be affected by changes in altitude or physical exertion? If so, list them:

In the event of either illness or an accident, we will attempt to telephone your emergency contact and/or your family doctor.

Doctor____ Phone____________________________________

I the undersigned below has read the medical consent, release and assumption of risk (reverse side) and hereby agrees to same, and has answered all above questions to the best of his or her ability:

______________________ ____
DATE STUDENT OR PARTICIPANT

______________________ ____
DATE PARENT/S OR GUARDIAN (if under 18)

Sworn to before me and subscribed by__________________________
in my presence the __________ day of _________, _________.

____
NOTARY

NOTE: Return to Carolyn Exner in the Central Office in Achatz