



Medical History Review

Venture Outdoor Leadership
University of North Carolina at Charlotte

INSTRUCTIONS TO PARTICIPANTS/ STUDENTS

1. Complete the Medical History Form on the following pages.
2. Bring or send this document to your personal physician or health care provider to (1) review and (2) complete page 2.
3. Submit the completed form to the address below.

INSTRUCTIONS TO HEALTH CARE PROVIDER

Venture Bound is a five-day, four-night, backpacking program in the Western North Carolina mountains. The program includes extended periods in remote areas where evacuation to comprehensive medical care can take hours. Weather conditions can be extreme. Prolonged storms, high winds, intense sunlight, hot and cold temperatures, as well as sudden immersion in cold water are possible.

The participant will be carrying a pack of 25-40 pounds on uneven terrain. While participating in this course, they will be outdoors for 24 hours/ day, including sleeping outdoors. Participants will experience long days requiring both physical and emotional stamina. The group will live in close community during this program with little opportunity for self-directed scheduling or time alone.

Each student is expected to take good care of their health. The ability of the student to (1) persevere in challenging circumstances (such as cold weather, long days, sore muscles, and difficult group dynamics), (2) be of sound mind to make good decisions, and (3) be of average to above average physical ability will play a significant part in the safety of the individual and the group. Prior physical conditioning and a positive mental attitude are a necessity.

Participants find wilderness experiences to be physically, mentally, and emotionally demanding. In the interest of personal safety for all participants, please consider the above description carefully when reviewing this Medical Form. A "positive" response will not automatically cancel this person's enrollment. All forms and comments from medical professionals are reviewed by qualified and approved UNC Charlotte personnel.

PLEASE NOTE - YOUR DETAILED COMMENTS WILL EXPEDITE THE REVIEW OF THIS FORM.

Email to: venturedept@charlotte.edu

Or mail to:
Venture Outdoor Leadership
9201 University City Blvd
Charlotte, NC 28223

MEDICAL REVIEW BY PERSONAL PHYSICIAN / HEALTHCARE PROFESSIONAL

PHYSICIAN AGREEMENTS AND SIGNATURE

Please complete the following after reviewing the completed Medical History Form included with this letter/ medical review form. If you have any questions, you can contact Venture Outdoor Leadership at **venturedept@charlotte.edu** or **704-687-06970**

PHYSICIAN'S NAME: _____
(person completing this form)

PRACTICE INFORMATION

Practice Name: _____

Address (1): _____

Address (2): _____

City, State and Zip Code: _____

Work Phone Number: _____

Work E-mail Address (optional): _____

Date of Last Physical: _____

Findings Pertinent to Venture Bound (use separate sheet if necessary)

On the basis of the program information provided on Page 1 of this document, your examination of this individual, and review of their completed Medical History Form, **do you feel this individual can participate in the Venture Bound program?**

- ☐ Yes, without limitations
- ☐ Yes, with limitations
- ☐ No
- ☐ Other

If you responded "Yes, with limitations", "No", or "Other" please provide more information (use separate sheet if necessary)

By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a physical signature.

Physician Signature

Date

MEDICAL HISTORY FORM

Patient's Full Name: _____

Date of Birth: _____ UNC Charlotte ID Number: _____

E-mail Address (*UNC Charlotte email if known*): _____

Mobile/ Cell Phone Number: _____ Home/ Alternate Phone Number: _____

Permanent Address: _____

Emergency Contact Name: _____ **Relationship:** _____

Emergency Phone Number: _____

Health Insurance Company: _____

Policy Holder's Name: _____ Holder's Date of Birth: _____

Policy/ Group #: _____ Member ID: _____

Continued on the next page...

GENERAL MEDICAL HISTORY

☐ YES ☐ NO Have you been directed to carry an **INHALER** or other breathing aid?

If yes, please describe what triggers your asthma (or other relevant condition) and how often you use your inhaler/ breathing aid.
(use separate page if needed)

☐ YES ☐ NO Are you prescribed **Epinephrine** (e.g. Epi Pen)?

☐ YES ☐ NO Have you ever had or do you currently have any **ALLERGIES**, including medications, the environment, and foods?

☐ YES ☐ NO Have you ever had an allergic reaction **to insect stings**?

If yes to either of the above, please:

- 1- List each allergen
- 2- Describe your reaction to each allergen
- 3- Include any treatments for the reaction

(use separate page if needed)

☐ YES ☐ NO Have you been advised to **limit your activity** in any way?

If yes, please describe:

- 1- Why limiting activity was recommended
- 2- In what way activity should be limited

(use separate page if needed)

☐ YES ☐ NO Are you **pregnant** or trying to become pregnant? *If pregnant, be aware that climbing harnesses can cause problems.*

What **medical accommodations** can we provide?

ADDITIONAL MEDICATIONS AND CONDITIONS

Date of last **TETANUS** vaccination: _____

List all **MEDICATIONS** that:

- you take regularly
- you expect to take / have while on this trip

Include over-the-counter, supplements, and prescriptions.

(use separate page if needed)

For each medication above, please list:

- Why you take each medication
- The dosage
- How frequently you take the medication

(use separate page if needed)

What are your **CURRENT CONDITIONS** or **ILLNESSES**, including those that you are currently in treatment and/or other medical care/ supervision for?

Include psychiatric as well as physical conditions/ illnesses.

(use separate page if needed)

For each condition/ illness listed above, briefly describe how you manage/ treat the condition/ illness.

(use separate page if needed)

What limitations have been advised due to the above conditions/ illnesses?

(use separate page if needed)

What **BONE** or **JOINT INJURIES** have you had in the past? List:

- Where on the body the injury occurred
- When they occurred and
- Any ongoing limitations/ concerns.

(use separate page if needed)

What **SURGERIES** have you undergone? List:

- Where on the body
- When they occurred
- Any ongoing limitations/ concerns

(use separate page if needed)

Continued on the next page...

CARDIAC RISK FACTORS

Research has demonstrated that adventure activities can raise heart and respiration rates in any participant and that persons with a history of heart and respiratory problems can be placed at extreme risk. Individuals with 3 or more cardiac risk factors may also be at risk.

If you have 3 or more cardiac risk factors, consult with your health care provider and obtain written approval from them to participate in Venture Outdoor Leadership activities.

Without written approval from your health care provider, you may be asked to limit your participation in such activities.

Cardiac risk factors include:

- Age (Men over 45, Women over 55)
- Tobacco use
- Family history of heart disease
- High blood pressure
- Elevated cholesterol
- Diabetes

Current Age: _____

☐ YES ☐ NO Do you exercise **less than** 1x per week?

☐ YES ☐ NO Do have a **history of heart problems?** (e.g. high cholesterol, heart murmur, elevated blood pressure, heart attack, cardiac-related surgery, etc.

If yes, please provide please provide as many details as you are able, including

- Diagnoses
- When you were diagnosed
- Treatments/ care for the condition
- Any ongoing medical supervision/ care

(use separate page if needed)

☐ YES ☐ NO Do you have **genetic family** member(s) with a history of heart problems, including high cholesterol, heart murmur, elevated blood pressure, heart attack, cardiac related surgery, etc.

If yes, please provide as many details as you are able, including

- Your relationship to them
- Their diagnoses
- When they were diagnosed

(use separate page if needed)

☐ YES ☐ NO Do you get **squeezing, tightness** or **pressure** in your chest during exercise?

If yes, please describe including:

- Description of the squeezing, tightness, pressure, etc.
- What causes it
- What alleviates it (if anything)
- How long it typically lasts
- Any care/ treatment you have received or are currently receiving

(use separate page if needed)

☐ YES ☐ NO Do you use **TOBACCO** in any form, including vape, cigarettes, snuff, etc.?

Anything else you want to share with the medical review team about your cardiac risk factors?

(use separate page if needed)

What other health concerns should we know about you before participating in a Venture Outdoor Leadership program/ trip? List them here with brief descriptions.

(use separate page if needed)

Continued on the next page...

AGREEMENTS AND SIGNATURE

Read each statement carefully. **If you agree, click/ select the box next to each statement.** If you have any questions, you can contact Venture Outdoor Leadership at venturedept@charlotte.edu or 704-687-0697

- ☐ I affirm that the information provided in this form is a complete and accurate statement of the physical and psychological factors which may affect my participation on a Venture Outdoor Leadership program.
- ☐ I understand that failure to disclose information could result in serious harm to me and other participants.
- ☐ I agree to hold harmless Venture Outdoor Leadership and UNC Charlotte from any liability, claim, or expense resulting, directly or indirectly, from my failure to disclose relevant information. This information will be kept confidential except as needed in an emergency.
- ☐ In case of treatment, I consent to the release of medical records and accident report forms to insurance companies, my employer (if at Venture Outdoor Leadership as part of a company sponsored program), or agencies deemed appropriate by Venture Outdoor Leadership.
- ☐ I hereby consent to first aid treatment and evacuation, and to treatment, anesthesia, and/or operations in a medical facility should that become necessary in the event of a medical emergency while a participant in and relating to Venture activities.

Any **additional comments** for Venture Outdoor Leadership or the medical review team?

(use separate page if needed)

By typing my name below, I understand and agree that this form of electronic signature has the same legal force and effect as a manual signature.

Patient / Student Signature

Date

Parent/ Guardian name/ signature if under 18 years of age

Parent/ Guardian Signature

Date

RETURN COMPLETED MEDICAL HISTORY FORM TO

Venture Outdoor Leadership

Belk Gym, Suite 108

9201 University City Blvd

Charlotte, NC 28223

venturedept@charlotte.edu

704-687-0697