

PROJECT W.I.L.D. MEDICAL HISTORY FORM

(NAME OF PARTICIPANT: \_\_\_\_\_)

All information on this form is kept confidential. Only a medical reviewer and appropriate Project W.I.L.D. staff will review it. For your safety, please ensure all information on this form is accurate and complete. Medical conditions do not automatically disqualify you from participation and we will try to accommodate any medical conditions or restrictions you have. Project W.I.L.D. reserves the right to refuse admission to anyone medically unfit for the program's activities. If you answer "yes" to a critical medical question, your medical provider must review your condition and clear you to participate. If you do not answer "yes" to any critical medical questions no review is necessary. Write legibly in ink.

**Personal Info:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Country: \_\_\_\_\_ Gender: Male / Female (circle) Primary phone: (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_

**General Medical Information (to be completed by the participant):**

Do you regularly take any medications? (list on next page and bring on trip) No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have any adverse reactions or allergies to any medications? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Have you ever had an allergic reaction to a bee sting or insect bite? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have asthma? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have a prescribed inhaler? (describe on next page and bring on trip) No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have any concerns that we or emergency personnel should be aware of? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Are you currently undergoing treatment for any medical condition? No: \_\_\_ Yes (elaborate on back): \_\_\_

**Dietary Restrictions (to be completed by the participant):**

Do you have any dietary restrictions, including vegetarianism? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Are you vegetarian or vegan? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have any food-related allergies? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Have you used iodized water before? (we disinfect water with iodine) No: \_\_\_ Yes (elaborate on back): \_\_\_  
Have you had any complications or reactions associated with the use of iodine? No: \_\_\_ Yes (elaborate on back): \_\_\_

**Critical Medical Information (to be completed by the participant):**

For any "yes" answers in the critical medical information section, the medical/surgical provider who treated you or your personal medical provider must review these medical conditions, clear you to participate, and sign below.

Have you ever had a severe allergic reaction requiring medical attention? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Have you had surgery in the past 12 months? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Have you required hospitalization in the past 12 months? Why? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Have you ever required hospitalization for an issue related to mental health? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have any spine or back injuries or ankylosing spondylitis? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have any orthopedic injuries or joint injuries? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have any chronic or progressive illnesses? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have any respiratory illnesses, recurring or current? No: \_\_\_ Yes (elaborate on back): \_\_\_  
Do you have any cardiac or cardiovascular conditions, recurring or current? No: \_\_\_ Yes (elaborate on back): \_\_\_

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Are there any significant restrictions on your physical activity? No: \_\_\_\_ Yes (elaborate on back): \_\_\_\_  
Do you have any other medical conditions relevant to the program? No: \_\_\_\_ Yes (elaborate on back): \_\_\_\_

**MEDICAL PROVIDER (to be signed by the relevant medical provider if any critical questions were answered "yes"):**

I, the undersigned, have discussed all relevant medical issues with the participant including those noted above and clear the participant to participate in Project W.I.L.D. Any qualifying statements, comments, or restrictions are noted below:

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Comments (attach a separate sheet if necessary): \_\_\_\_\_

Please explain any "yes" answers from the questions above in the space provided on the back of this sheet. Include specific symptoms, frequency of occurrence, duration of symptoms, date of last occurrence, care for your symptoms, and any restrictions associated with your condition. Also include names of any medications to which you have had adverse reactions, any medications you are currently taking and/or will be taking during the trip, and any information you want provided to emergency personnel in case of a medical emergency (attach a separate sheet if necessary):

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

List any medications you are currently taking: (bring these on the trip)

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

Please explain and specify any "yes" answers you have from the dietary restrictions:

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

**Emergency Contact:**

Name: \_\_\_\_\_ Relation to participant: \_\_\_\_\_

Primary phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Secondary phone (if applicable): (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**PARTICIPANT ACKNOWLEDGEMENT (to be signed by the participant):**

I, the undersigned, have discussed all relevant medical issues and critical "yes" answers above with my medical provider and have been cleared to participate in Project W.I.L.D. The information I have provided above is complete and accurate to the best of my knowledge. I understand that only a designated medical reviewer and the appropriate Project W.I.L.D. staff will view this information. I authorize the medical reviewer to discuss this information with my medical provider, parent/guardian or the Project W.I.L.D. staff as needed to determine my fitness for this activity.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**LEGAL GUARDIAN ACKNOWLEDGEMENT (to be signed by legal guardian if participant is under 18):**

PROJECT W.I.L.D. MEDICAL HISTORY FORM

(NAME OF PARTICIPANT: \_\_\_\_\_)

I, the undersigned, as parent or guardian of the above designated Project W.I.L.D. program participant who is under the age of 18 years, have discussed all relevant medical issues and critical "yes" answers above with my child's medical provider and he/she has been cleared to participate in Project W.I.L.D. The information I have provided above is complete and accurate to the best of my knowledge. I understand that only a designated medical reviewer and the appropriate Project W.I.L.D. staff will view this information. I authorize the medical reviewer to discuss this information with his/her medical provider or the Project W.I.L.D. staff as needed to determine his/her fitness for this activity.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Primary phone: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

***MEDICAL REVIEWER SECTION (to be signed by Duke Student Health Reviewer):***

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments: \_\_\_\_\_

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