Adult Confidential Medical Record

Office Use Only

Follow-up
Approval

Complete as directed and return to: School Address

Group Name _____ Date _____

INSTRUCTIONS

Please fully complete and return this form as soon as possible in order to allow us adequate time for review and possible follow-up questions. We will determine the status of your participation after review of this form. We may require further evaluation by a physician in order for you to fully participate. If you choose to not proceed with the recommended follow-up, you may have the option of limited participation (based on our assessment of your medical constraints). Please return the form, regardless of what choice you make.

NOTE: Most of our programs are structured to accommodate various levels of participation. Regardless of your participation status, you will be able to be fully interactive with your group during most of the program activities. If you arrive at the program without a pre-reviewed medical record, your status will be as OBSERVER, only.

PART I General Information

APPLICANT

Name _____
Gender ☐ Male ☐ Female
Age _____ DOB ____/____/____ SS# _____
Address _____ Apt. ____
City/State/Zip _____

Daytime Phone # (_____)_____
Evening Phone # (_____)_____
FAX # (_____)_____
email Address _____
Do you speak/understand English? Yes ☐ No ☐

EMERGENCY CONTACT

Name _____
Relationship _____
Daytime Phone # (_____)_____
Evening Phone # (_____)_____

PHYSICIAN

Name _____
Phone # (_____)_____
FAX # (_____)_____
email Address _____

INSURANCE INFORMATION

Each participant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance. Please answer the following questions for our insurance records:

Insurance Company Name _____ Policy/Certificate # _____
Prescription Plan # _____ Telephone # (_____)_____

PART II Medical Information

A. Allergies (Including allergies to medicines, foods, insect bites/stings)

NONE ☐ or...

Allergy	Reaction	Medication Required (if any)

B. Current Medications (Including psychiatric and over-the-counter)

NONE ☐ or...

Medication	Taken For: (Symptom/Condition)	Dosage	Date Started	Current Side Effects

PART III Health Profile

#	Please √ one--If yes, describe below	Y	N	#	Please √ one--If yes, describe below	Y	N
1.	Seizure within the past 1 year			**5.**	Medical Device, i.e. inhaler		
2.	Hospitalization / Emergency Room / Urgent Care visit within the past 1 year			**6.**	Neck / Back / Shoulder / Knee / Ankle or other orthopedic problem		
3.	History heart attack, by-pass/angioplasty/angina			**7.**	Currently Pregnant		
4.	Other cardiac conditions, e.g. heart murmur or other rhythm abnormality			**8.**	Other medical issues / illnesses / symptoms / requirements		
#	Describe						
#	Describe						

PART IV Cardiovascular Fitness Evaluation REQUIRED INFORMATION

A. Statistics / Vital Signs (We will be unable to evaluate you for participation in this program without this information)

Blood Pressure must be taken within 6 months of course start. You may take your own blood pressure using apparatus at local department or drug store.	Age _____ Height _____ft. _____ins. Weight _____lbs. Blood Pressure Reading _____/_____ Date Taken _____ IF BP is over 150/90, please take a second reading: Second BP Reading _____/_____ Date Taken _____

B. Cardiovascular Risk Factors

YES	NO	
☐	☐	Diagnosed high blood pressure, even if being controlled with medication
☐	☐	Smoker
☐	☐	Diabetic requiring medication
☐	☐	Known abnormally high cholesterol level or on a diet or medication for a lipid abnormality
☐	☐	Family history (parent/sibling) of heart attack, coronary artery by-pass/angioplasty, or sudden, unexplained death before age 55
☐	☐	Unexplained chest pain/pressure, shortness of breath, heart palpitations, sweats/exertional dizziness/ faint spells

C. Current Exercise Activity (Needed as important assessment tool)

Please list the activities you engage in daily or weekly which indicate your current fitness level. Be sure to include activities such as walking a pet, mowing your lawn—or activities such as playing basketball, swimming, skiing, etc.

Activity	Frequency	Approximate Time / Distance	Leisurely	Moderately	Intensely

Ohio Wesleyan University recommends that all of its participants have a current tetanus immunization (within 10 years).

PART V Signature Required

All information will remain confidential. Over the years, many students with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow participants. I will be attending a Ohio Wesleyan University program and I give permission for any emergency anesthesia, operation, hospitalization or other treatment that may become necessary.

_____ _____/_____/_____

Applicant Signature Date